Spring 2021

Disruptive Communication Among the Interdisciplinary Team: Gaining Insight and Providing Nurse Education

Kristen Marie Anderson
Pittsburg State University, klinn@gus.pittstate.edu

DISRUPTIVE COMMUNICATION AMONG THE INTERDISCIPLINARY TEAM: GAINING INSIGHT AND PROVIDING NURSE EDUCATION

A Scholarly Project Submitted to the Graduate School
in Partial Fulfillment of the Requirements
for the Degree of
Doctor of Nursing Practice

Kristen Marie Anderson

Pittsburg State University

Pittsburg, Kansas

May 2021

ACKNOWLEDGEMENTS

I would like to thank Dr. Kristi Frisbee for her support, guidance, and patience. I would also like to thank Dr. Amanda Alonzo, Dr. Alicia Mason Collins, and Dr. Amy Hite for their valuable insight and recommendations to improve this research project. I truly appreciate the two participating hospitals and all of the nurses for agreeing to contribute to the study. Finally, I would like to thank my family for their unconditional love and support throughout my graduate education.

DISRUPTIVE COMMUNICATION AMONG THE INTERDISCIPLINARY TEAM: GAINING INSIGHT AND PROVIDING NURSE EDUCATION

An Abstract of the Scholarly Project by
Kristen Anderson, BSN, RN

The purpose of this study is to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators of disruptive communication. Understanding the consequences of disruptive communication can help educators articulate the need for training in conflict management and therapeutic communication methods. It can also aid healthcare providers to be more conscious of their behavior in the professional setting. Seven research questions related to communication were developed and analyzed in this study. The author developed a pre-education survey that included demographics, multiple-choice questions, and open-ended questions to assess the nurses' knowledge and feelings regarding disruptive communication in a mixed-method, cross-sectional design to evaluate knowledge and hear the voice of the participant. The post-education questionnaire included multiple-choice questions, assessing the nurses' feelings toward addressing disruptive behavior. Statistical analysis was utilized to calculate the frequency, percent, and mean of quantitative data. This study contributes to nursing knowledge, supporting the need for positive communication techniques, revealing adverse outcomes from disruptive communication, and discussing the need for continuing education. Effective communication can contribute to the capstone of healthcare: patient safety and high-quality care. Therefore, continuing education, institutional policy, and

legislative policy need to be implemented to improve communication among the interdisciplinary team.

TABLE OF CONTENTS

LIST OF TABLES

TABLE……PAGE

LIST OF FIGURES

CHAPTER I

Introduction

While working on a cardiology floor in the Midwest for over three years, this author discovered a universal indignation among the floor nurses; spited by various nurse practitioners and doctors. When asked to recount their experiences with nurse practitioners and doctors, nurses described instances of getting yelled at, being talked down to, hung up on, and even completely ignored. One nurse stated:

> One night, I had a patient who fell at 0300. Naturally, I called the on-call physician expecting to obtain an order for a CT of the head. After he picked up, I stated, 'hello, Dr. C. I have your patient, Mr. Smith in room 209. I wanted to inform you that he fell out of bed and hit his head.' and then I heard the click of him hanging up on me. I didn't know what to do, and there wasn't a nurse practitioner on call. So, I just wrote a note and moved on.

Another nurse shared her experience:

> I had a [arterial] cut-down where the patient's groin site started bleeding. There isn't a protocol except to hold pressure. It took a while to get a call back from the cardiothoracic surgeon, so I just held pressure until he answered his page. When we finally got a hold of him, he started screaming at me; accusing me of ruining his graft. At the time, I was scheduled to transfer from Cardiology to the ICU

within the next couple of weeks. After that experience, the surgeon told my supervisor that I was not to transfer to the ICU or ever take cardiothoracic surgery patients again. If he would have answered his page sooner or written specific orders to not hold direct pressure on the graft, the situation could have gone better.

Dozens of similar stories were shared among the unit. Recently, there has been push-back from nurses across the unit who are searching for ways to alert administrators of the presence of a hostile work environment. After speaking with her floor supervisor, this author decided that a research project could benefit the hospital by providing information on disruptive communication, how often disruptive communication occurs, what types of disruptive communication are present, and what outcomes come from disruptive communication.

Description of the Clinical Problem/Issue

According to the literature, communication errors are the leading cause of inadvertent patient harm. Healthcare providers need to be aware of communication errors, for communication errors are a daily occurrence that can be prevented. Leonard et al. (2004) report:

> Analysis of 2455 sentinel events reported to the Joint Commission for Hospital Accreditation revealed that the primary root cause in over 70% [of inadvertent patient harm] was communication failure. Reflecting the seriousness of these occurrences, approximately 75% of these patients died. (p.86)

This statement reflects the seriousness of the issue, validating the potential harm that disruptive communication can cause patients.

Kimes et al. (2015) stated, “The focus on a culture of safety within health care emphasizes the need to limit any controllable negative influence on patient safety” (p.225). Therefore, healthcare as a whole needs to do better when confronting issues such as disruptive communication. It is unacceptable for nurse administrators to tell nurses, “that’s just the way things are” as nurses try to confront the issue when it is the patients who are ultimately being harmed.

Although some changes have been made to improve communication in healthcare, more needs to be done to advocate for nurses. Many facilities hold policies that discourage, or even prohibit disruptive behavior (Rosenstein & O’Daniel, 2008; Kimes et al., 2015). However, doctors are often viewed as a precious resource to hospital administrators because of their extensive knowledge and expertise, the revenue they generate, and the general scarcity of doctors. Thus, their inappropriate behavior often goes ignored. On the other hand, nurses are also valuable resources, and the country is experiencing a national shortage of them. If nurses feel as if their voices are not being heard, it could lead to issues with recruitment and retention (Robeznieks, 2015; Kimes et al., 2015, p. 223). Therefore, doctors, nurse practitioners, and hospital administrators need to be aware of the consequences of their actions and the risks they are taking by ignoring the disruptive behavior.

Significance

Disruptive communication has a significant influence on nurse satisfaction, turnover rates, and patient safety. Rosenstein & O’Daniel (2005) address satisfaction and patient safety by gaining nurse perspectives. Nurses reported, “Employee stress as a result of physician yelling resulted in decreased patient safety” (p. 25). Another nurse

stated, “Most nurses are afraid to call Dr. X when they need to, and frequently won’t call. Their patient’s medical safety is always in jeopardy because of this” (Rosenstein & O’Daniel, 2005, p. 25). Patient safety is the pinnacle of nursing. Therefore, if patient safety is repeatedly jeopardized, nurses may become dissatisfied with their work. Kimes, Davis, & Medlock (2015) found that “ineffective collaboration” caused nurses to feel “belittled, angry, and disrespected.” Due to the increased stress, anxiety, anger, and frustration that is caused by disruptive communication, it is stressed throughout the research that disruptive communication needs to be corrected; for it is believed to affect nurse retention rates.

Specific Aims/Purpose

The purpose of this study is to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators of disruptive communication. Understanding the consequences of disruptive communication can assist educators in articulating the need for training in conflict management and therapeutic communication methods. It can also aid healthcare providers to be more conscious of their behavior in the professional setting. This author hopes this will lead to increased job satisfaction for nurses, higher nurse retention rates, and better patient outcomes.

Theoretical Framework

Communication Accommodation Theory

The Communication Accommodation Theory (CAT) is an Interaction-Centered Theory, meaning the theory focuses on the interaction itself, or how participants utilize verbal and non-verbal behavior to facilitate the conversation (Baylund et al., 2012).

Baylund et al. (2012) describe CAT as, "the ways individuals modify their communicative behavior as a result of their communication with each other" (p.265). CAT allows individuals to "predict and explain" verbal and non-verbal cues that providers make to "maintain or decrease social distance" in communicating (Baylund et al., 2012, p.265). The two main concepts of CAT are divergence and convergence. Baylund et al. (2012) explain that a person may use divergence to indicate differences in communication styles (p.265). Convergence allows a person to match another's communication style usually indicating a positive connection. CAT acknowledges that providers may accommodate one another by considering the other participant's needs and the power dynamic within the relationship. Baylund et al. (2012) explain, "Those traditionally perceived as having greater power tend to be accommodated more than those with less power" (p.265). CAT has been limited to healthcare communication studies, focusing on "intergroup conflict among multi-specialty doctors" (Baylund et al., 2012, p.266). CAT can be utilized to determine how nurses and doctors perceive conversations through body-posturing, tone of voice, non-verbal cues, rate of speech, eye contact, and so on. The disadvantage of using this theory is it is mostly applicable to face-to-face communication. Doctors and nurses often communicate over the phone, so this theory would not be applicable for a study focusing on phone communication.

Social Exchange Theory

Another theory that can be applied to the study is the Social Exchange Theory (SET). SET interactions are interdependent, based on the idea that the exchange of social and material resources is the basis of human interaction (Cropanzano & Mitchell, 2005, p.874). According to Cropanzano and Mitchell (2005), SET emphasizes that

"interdependent transactions have the potential to generate high-quality relationships, although as we shall see this only will occur under certain circumstances" (p.874). Xerri (2012) describes SET as, "the social interactions tend to be mutually dependent and contingent upon the actions of another person" (p.4). SET contains the theory of reciprocity, based on the assumption that if one completes one good deed for another, a good deed will be returned, possibly at a later time (Xerri, 2012, p.4). Often, when nurses and doctors communicate, each party expects that they will gain something from the conversation, whether it is information, a medication, approval, respect, etc. When a doctor or nurse receives positive input from the opposite source, they are more likely to provide positive output in the future to the same source.

The Orchestra Theory

The Schutzian Lifeworld Phenomenological Orchestra Study performed by Valerie Malhotra (1981) provides an interesting and appropriate theoretical model for the project. The orchestra study describes how each member of an orchestra provides their own knowledge, experience, and talents to contribute to the orchestra as a whole. Malhotra (1981) states, "Each player must not only be conscious of his or her own part, but also of the parts of other musicians" (p.105). This is also true of healthcare workers. Each provider must understand the role of other team members to successfully carry out orders and provide exceptional care. Malhotra (1981) also explains that musicians may only hear certain parts being played, "but do not hear the entire musical piece while they are playing (Lancaster et al., 2015, p.276). Therefore, they must use quality verbal and non-verbal communication to understand each member is doing his or her part to contribute to the same goal. Like an orchestra, healthcare workers have different roles to

play, but collaborate to "create a cohesive final performance" (Lancaster et al., 2015, p.276).

Project (Practice) Question(s)/Hypotheses

1. What type of disruptive behavior are nurses experiencing?
2. How frequently do nurses experience disruptive behavior?
3. What outcomes do nurse's perceive result from disruptive behavior?
4. Do nurses perceive there is a relationship between communication and job satisfaction?
5. Is there a relationship between the frequency of disruptive behavior and the nurse's perception of the relationship between communication and job satisfaction?
6. How confident do nurses feel addressing disruptive behavior before an educational intervention?
7. How confident do nurses feel addressing disruptive behavior after an educational intervention?

Definition of Key Terms/Variables

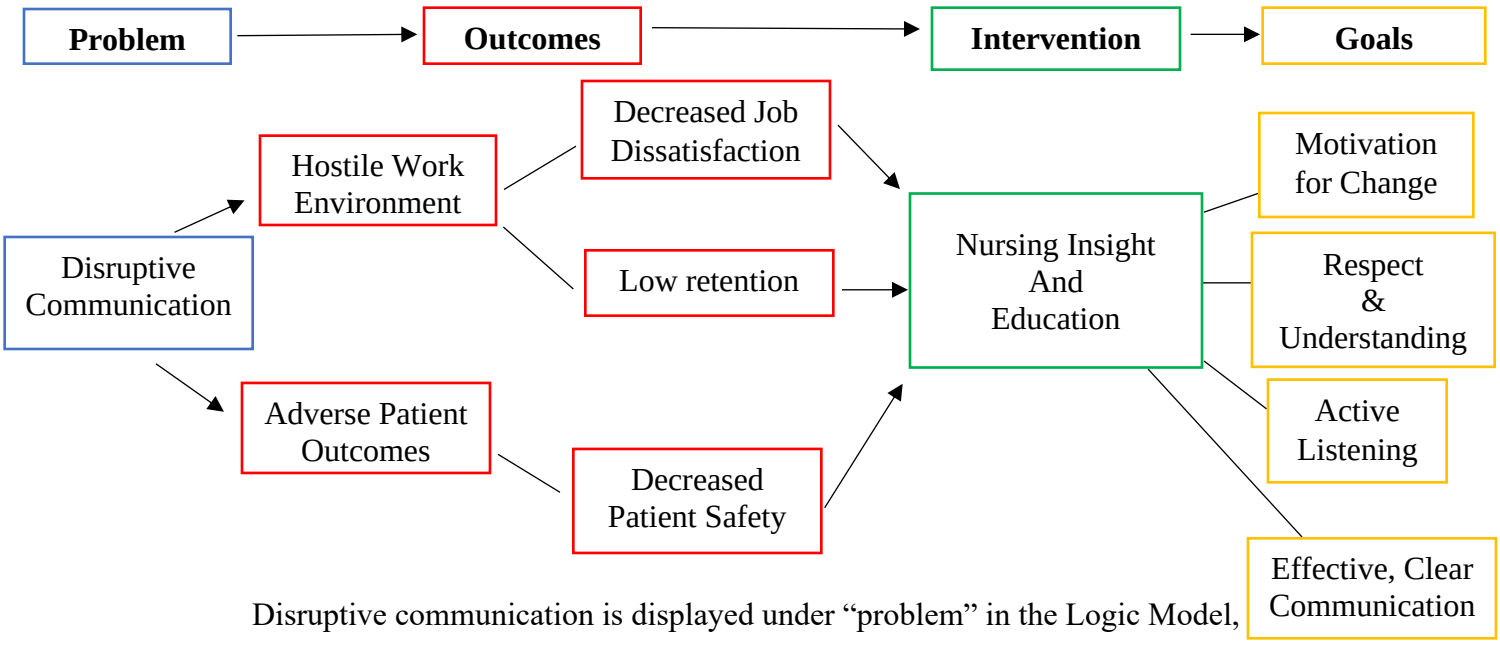
Disruptive communication: frequently used term to describe poor communication methods and behaviors. Belittling, yelling, sexual harassment, verbal outbursts, physical threats, degrading, and ignoring behaviors have all been identified as disruptive behavior (Higgins & MacIntosh, 2010; Rosenstein, 2009; Rosenstein & O'Daniel, 2008; Kimes et al., 2015, p.223)

Communication: "process by which information is exchanged between individuals through a common system of symbols, signs, or behavior; personal rapport;

information communicated: information transmitted or conveyed; a verbal or written message" (Merriam- Webster, n.d.). Leonard et al. (2004) describe communication in healthcare as intricate and highly important (p.85). McCaffrey et al. (2010) state "skilled communication focuses on critical communication proficiencies, including self-awareness, inquiry and dialogue, conflict management, negotiation, advocacy, and listening" (p.173). The concept and definition of communication seem simple. Why do healthcare providers struggle with effective communication?

Figure 1

Logic Model for the Research Project



Disruptive communication is displayed under "problem" in the Logic Model, leading to "negative outcomes," including adverse patient outcomes and hostile work environments. Hostile work environments can lead to decreased job satisfaction, which can result in low nurse retention rates. Adverse patient outcomes can lead to decreased patient safety, also resulting in low nurse retention rates. Providing an intervention

including nursing insight and education may lead to positive outcomes. These positive outcomes, or "goals," include motivation for change, respect and understanding, active listening, and effective, clear communication.

Summary of the Chapter

Disruptive communication is a universal issue in healthcare. However, it is often disregarded by unenforced policies, general disrespect, simply ignoring the issue, and a lack of education. Hospitals around the world have fallen victim to disruptive communication. In some cases, nurses attempted to inform their supervisors and administrators of the growing issue. In result, many were told "that's just how it is". Research has shown that this can cause a decrease in job satisfaction and work ethic (Rosenstein et al, 2005; Manojlovich, 2005). Communication not only affects nurse attitudes but can also affect patient safety. For example, Kimes et al. (2015) found, "nurses reported they often avoided subsequent interaction with doctors and were less likely to communicate effectively with them in future situations…one nurse reported she would 'exhaust all means possible' before contacting a physician" (p.226). Therefore, healthcare leaders should enforce zero-tolerance policies for disruptive communication within the healthcare setting while continuing to educate their staff on the importance of positive communication.

The purpose of the study is to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and inform healthcare providers and administrators of disruptive communication. Using the Communication Accommodation Theory, Social Exchange Theory, and Orchestra Theory, this author will

incorporate and identify communication techniques and teamwork methods within the project. Seven project questions were developed.

Through this project, nursing insight and education to nursing staff using Orchestra Theory, SET, communication techniques, and conflict management to promote a motivation for change, active listening, respect/understanding, and effective, clear communication will be provided. Many unnecessary errors, poor outcomes, and dissatisfaction can be prevented if healthcare providers respected one-another, and work as worked as a team.

CHAPTER II

Review of the Literature

Communication is an underrated and vital skill that all healthcare providers are expected to master. However, there have been reports of dissatisfaction, misinterpretation, medication errors, and mortalities due to poor communication. The literature does not put it lightly; "communication failures are the leading causes of inadvertent patient harm" (Leonard et al., 2004, p.85). The authors within the literature agree that when nurses, doctors, and nurse practitioners refuse to communicate in a healthy manner, it is ultimately the patient who suffers.

According to the literature, communication errors are the leading cause of inadvertent patient harm. Nurses and doctors need to be aware of communication errors, for communication errors are a daily occurrence that can be prevented. The Joint Commission for Hospital Accreditation reviewed 2455 sentinel events and found that over 70% of the cases resulted from communication failure among the interdisciplinary team (Leonard et al., 2004). Although some changes have been made to improve communication in healthcare, Zwarenstein et al. (2013) explain:

> Many problems of coordination and communication may arise from lack of a common cross-team understanding of the care priorities for a specific

> patient at a specific time and the resulting failure of individual team members to align their activities to those priorities, rather than simple miscommunication. (p.494)

This evidence provides insight into what is known about interprofessional communication in reference to the research literature. Common themes identified in the literature include patient outcomes, nurse and physician satisfaction, theories, and improvement strategies regarding interprofessional communication. This review will assess common variables linked to poor communication and will identify missing links in the literature.

Literature Synthesis

A search of CINAHL, Summon, Google Scholar, Medline, and PubMed was conducted using the terms *nurse, communication, physician, satisfaction, patient outcomes, interdisciplinary team, dissatisfaction, disruptive, inappropriate,* and *theory.* Results included a great deal of discussion on several topics including communication differences, disruptive behavior, communication techniques, nursing theories, patient outcomes, and satisfaction levels. Poor communication techniques were often linked to patient harm and undesirable outcomes. A total of 20 articles and one guideline were utilized for research. Interdisciplinary communication is the key concept reviewed in this synthesis. Qualities related to poor communication methods, interdisciplinary satisfaction, patient satisfaction, and communication techniques were reviewed to identify contributing factors and important concepts.

Qualities Related to Poor Communication Methods

Qualities such as communication differences and hierarchies can cause gaps in communication between nurses and doctors. Differences in communication methods may lead to misunderstanding and confusion between the two parties. Hierarchies may cause a disconnect between those who should be working together as a team. These qualities should be addressed with training and leadership to help people understand each other, encourage voice, and healthily coordinate care.

Communication Differences

Several issues contributing to communication gaps have been identified by the literature. The literature reviewed suggests that nurses and doctors are taught to communicate differently. In nursing school, nurses are taught to look at the 'big picture' and be very broad in their explanations, whereas doctors are taught to get straight to the problem and be concise. Nurses typically rely on care plans, goal sheets, and patient meetings to communicate issues, while doctors utilize short discussions focusing on medical issues (McCaffrey et al., 2010, p.173). McCaffrey et al. (2010) conducted a study surveying 462 nurses and 78 doctors, finding communication differences between the two disciplines. The nurses stated in their surveys that they felt that the communication styles utilized at work were ineffective, especially between doctors and nurses (McCaffrey et al., 2010, p. 173). Doctors reported they preferred to spend little time on communication, and they expect nurses to anticipate the doctor's needs and take orders correctly (McCaffrey et al., 2010). McCaffrey et al. (2010) state, "Doctors did not identify information obtained from nurses as particularly useful or

important, and often described it as bothersome" (p.173). The difference between the two communication techniques sparked frustration and impatience among nurses and Doctors. McCaffrey et al. (2010) discuss that the importance of communication is not emphasized within nursing schools, medical schools, and the workplace. They recommend development of a common language that is agreed upon, then distributed throughout the healthcare system to allow a good relationship between the two professions.

Disruptive Behaviors and Hierarchies

Hierarchies can lead to disruptive behavior by causing a divide between the interdisciplinary team. In healthcare, doctors are viewed as the highest-ranking member of the interdisciplinary team. Disruptive behavior from doctors has been identified and described in a variety of ways, including verbal outbursts, physical threats, degrading or insulting comments, ignoring behaviors, and sexual harassment (Higgins & MacIntosh, 2010; Rosenstein, 2009; Rosenstein & O'Daniel, 2008; Kimeset al. 2015). According to Robinson et al. (2010), "the well-entrenched hierarchical authority structure and sexism (even though women make up over one-third of the physician workforce) complicate nurse-physician communication" (p.206). Although many hospitals have adopted a "zero tolerance policy" regarding disruptive behavior, few have followed through with the policy, resulting in little improvement (Rosenstein & O'Daniel, 2008; Kimes et al., 2015, p. 223). Doctors are considered a "precious resource", making health care organizations more likely to tolerate inappropriate behavior displayed by doctors (Kimes et al., 2015, p.227). Dixon-Woods et al. (2019)

discuss the hierarchy's "untouchables," or doctors who hold a significant amount of power and influence. Dixon-Woods et al. (2019, p.580) explain that the poor behavior of untouchables is derived from their revenue generation or professional position. They are often seen as unapproachable and can be difficult to discipline, leading to an environment of fear and hostility.

Kimes et al. (2015) found within their study that disruptive behavior was a frequent experience when 12 out of 15 (75%) participants reported disruptive behavior within a surgical department (p.225). In a study conducted by Robinson et al. (2010), a nurse vocalized, "he said in the presence of the patient, 'it is amazing on this floor; the nurses don't know what they are doing'" (p.212). Nurses reported feeling that they annoyed Doctors when they contacted them for clarification of orders (Kimes et al., 2015, p.226).

Ineffective collaboration impacts nurses' confidence and emotional state, often leading them to avoiding interaction with doctors in future situations (Kimes et al. 2015, p.226). As Kimes et al. (2015) discusses, "one participant reported disruptive physician behavior often 'intimidates nurses into not questioning because they want to keep the peace'" (p.225). This behavior is dangerous both for patients and for nurses who will be less willing to notify doctors of any indication of a problem in fear of being reprimanded. It is the nurse's responsibility to advocate for his or her patient. If nurses are uncomfortable communicating with doctors, there is likely to be an error or mishap (Kimes et al., 2015, p.225). Although researchers disagree upon how much negative influence disruptive behavior has on patient outcomes, Kimes et

al. (2015) suitably states that the focus should be on limiting "any controllable negative influence on patient safety" (p.225).

Satisfaction of the Interdisciplinary Team

Communication is highly associated with job satisfaction. Doctors and nurses are expected to communicate with each other to obtain the 'big picture' of a patient's situation. However, nurses and doctors are both guilty of letting information "slip through the cracks" through poor communication. Burroughs and Bartholomew (2014) indicate that communication failures result in distancing measures. For instance, nurses can withhold information, be unavailable for updates, or refuse to communicate with doctors. Doctors can display unavailability, use an irritated tone of voice while speaking to a nurse, or display body language to "nonverbally portray that it is unnecessary to converse with a nurse" (Burroughs & Bartholomew, 2014, p.60). After collaborating toward better communication skills, nurses and doctors, alike have responded positively toward new communication practices.

Physician Satisfaction

Physician responses provided helpful perspective in the literature. Doctors expressed appreciation for clarity and precision, collaborative problem solving, maintenance of mutual respect, an authentic understanding of one's professional role, and a calm and supportive demeanor under stress (Robinson et al., 2010, p.209-211). The most popular response expressed by participants in the study that Robinson et al. (2010) conducted was, "the need for straightforward unambiguous communication" (p.210). Doctors and nurses need to communicate

their needs clearly and effectively to fully understand each other. If either party "beats around the bush" to spare feelings, the language may be misinterpreted, possibly resulting in an undesirable outcome. One of the doctors shared his experience in Robinson et al.'s (2010) study, describing an outcome of a conversation with a resident about a patient's discharge (p.210). The resident responded, "…yeah, yeah, yeah. The patient is going home. Fine" (Robinson et al., 2010, p.210). When the doctor followed up the next day, it turned out the patient never went home and the nurse did not know anything about the discharge (Robinson et al., 2010). The patient was not harmed in the situation, but a financial burden was forced upon them by staying an unnecessary night.

Nurse Satisfaction

A physician's actions and communication styles often play a role in nurse's job satisfaction (Coeling & Cukr, 2000; Manohlovich, 2005, p. 367). If disruptive communication is tolerated, it can be devastating; nurses are considered a scarce resource as a result of the nursing shortage and disruptive communication can cause nurses to leave a workplace (Kimes et al., 2015, p. 227). Throughout the literature, after the implementation of communication techniques, nurses reported higher satisfaction ratings. Although most of the articles reported an increase in nurse satisfaction ratings, Robinson et al. (2010) explained in detail what contributed to contentment. "Establishment of a relationship was seen as almost a precursor to communication" (213), stated Robinson et al. (2010), "…participants had to feel comfortable with each other in order to communicate effectively". Nurses feel that when they can establish a

trusting relationship with a physician, they are more likely to express concerns and participate in collaboration.

Nurses also appreciate teamwork and feel that it is beneficial when team members come together to solve problems (Robinson et al., 2010, p.213). It is frustrating for nurses when Doctors do not understand or respect the nursing profession or their scope of practice (Robinson et al., 2010, p.213). Robinson et al. (2010) explains, "it would be difficult for communication to be perceived as respectful if it was not based on an authentic understanding of what one brings to the situation" (p.214). They suggest implementing interprofessional education for nurses and doctors to develop a true understanding of each other.

Patient and Family Satisfaction

The literature suggests that communication directly affects patient outcomes and satisfaction. Patients benefit when both professions (doctors and nurses) seek each other out for "routine and complex decision-making" (Robinson et al., 2010, p.210). When Doctors and nurses do not collaborate, patients and family members may experience confusion, dissatisfaction, delays, and re-admissions (Zwarenstein et al. (2013). Riskin et al. (2017) affirms, "rudeness can debilitate intervention acuity, thus resulting in poorer medical treatment and…potentially catastrophic clinical outcomes" (p.8). In Robinson et al.'s (2010) study, patient care was improved when nurses and Doctors could rely on each other (p.211).

Khan et al. (2015) performed a study that surveyed pediatric patient's parents. From the study, Khan et al. (2015) gained information on the

relationship between communication and patient/family satisfaction. “On multivariable analyses, parents’ ratings of their direct communications with doctors and nurses, and their observations of teamwork and communication between doctors and nurses, were significant predictors of top-box overall experience” (p.6). The research indicates that improving communication (especially on night shift) can significantly improve a patient or family member’s hospital experience. Khan et al. (2015) suggests that further research needs to be conducted, specifically regarding night shift, teamwork, and communication (p.8).

Methods to Improve Communication

Methods of communication need to be observed to try to mend broken relationships among nurses and Doctors. Linking factors in the work environment and nurse communication can provide insight into how to improve nurses’ perceptions of communication with Doctors (Manojlovich & DeCicco, 2007, p.541).Common methods include frequent physician-nurse interactions, education, and the use of SBAR.

Frequent Physician-Nurse Interactions

There were many recurring themes throughout the literature involving different techniques to improve communication. Frequent physician-nurse interactions through rounding together and specific floor assignments for doctors proved to be beneficial for nurse and physician satisfaction, as well as patient outcomes (Gordon et al., 2011). Important factors for communication include

clarity, precision, collaboration, mutual respect, and an understanding of professional roles (Robinson et al., 2010).

Education

Nurses and Doctors need to be reminded of the importance of communication and how it can benefit their practice. McCaffrey et al. (2010) suggests nurses and Doctors need to be informed of the importance of communication and how collaboration can contribute to positive patient outcomes (p.174). McCaffrey et al. (2010) also propose that cultural differences and body language need to be discussed when teaching communication (p.175). Body language accounts for 67% of actual messages received by the listener (Dixon et al., 2006; McCaffrey et al., 2010). Role-playing is a great teaching strategy that can be used to teach participants how to interpret and display appropriate body language (McCaffrey et al., 2010). Scenarios and practice simulations could be used to advance listening skills, improve expressing clear messages, gain an appreciation of the significance of body language, and learn how to use negotiation and conflict resolution (McCaffrey et al., 2010).

Educating nurses and doctors of each other's roles may also improve communication through understanding and mutual respect. Education plays an important role in effective and safe communication. It is highly encouraged that medical schools, nursing schools, residency programs, and hospitals implement education resources to improve communication methods. Leonard et al. (2004) agree, "To date, we are seeing that teaching and embedding a few basic tools and

behaviours can provide tremendous clinical benefits. We have seen improved cultural measures—attitudes surrounding teamwork and safety climate" (p.90).

SBAR

SBAR is an effective tool used throughout healthcare to create a standardized and predictable communication method. SBAR stands for situation (what is going on with the patient), background (what is the clinical background or context), assessment (state findings and what one thinks the problem is), and recommendation (clearly state what one is expecting to gain from the conversation) (Leonard et al., 2004). This method allows nurses to "briefly and concisely" relay information to doctors (Leonard, et al., 2004, p.86). Surprisingly, Leonard et al. (2004) was the only source in the reviewed literature that mentioned SBAR and how it can improve communication between nurses and doctors.

Face-To-Face Communication

A recurring theme throughout the literature was the importance of face-to-face interaction. Both-doctors and nurses expressed an appreciation for the opportunity to build relationships and trust amongst each other (Gordon et al., 2011; Lancaster et al., 2015). Gordon et al. (2011) express, "Increasing face-to-face communication between nurses and doctors could potentially improve timeliness of action, accuracy of performance, and understanding, openness, and collaboration among caregivers" (p.427). Gordon et al. (2011) explain that face-to-face interaction allows for an exchange for nonverbal cues and allows nurses

and Doctors to identify each other, contributing to, “an atmosphere supporting openness and collaboration” (p.47).

Poor Communication and Patient Outcomes

Poor communication has been linked to adverse patient outcomes in prior research. In a prospective cohort study performed by Khan et al. (2010) poor “physician-nurse interactions are associated with patient mortality and readmissions. Teamwork has been correlated with patient outcomes and quality care” (p.7). Several articles had the similar message, “communication failures are the leading cause of inadvertent patient harm” (Leonard et al., 2004, p.85). Improving communication is an underrated yet imperative skill that all healthcare workers need to develop on. A participant in Lancaster et al.’s (2015) study perfectly explained why communication is so important:

> Communication is essential in any field. In medicine, it is particularly important because you delegate work on behalf of the patient. You have to be clear on your assessments and management plan, and this has to be laid out very carefully to the patient, your colleagues, to nursing staff, and aides who are participating in care. (p.280)

Nurses and Doctors need to acknowledge this, for if communication fails, it is ultimately the patient who loses.

Summary

Numerous studies have been developed to understand what is causing miscommunication, to learn how to improve communication among the interdisciplinary team, and to link poor communication methods to patient harm.

The literature thoroughly discussed the importance of utilizing proper communication to ameliorate job satisfaction between doctors and nurses, improve patient and family satisfaction with care, and to validate the need for the use of appropriate communication techniques. Descriptive research also identified the effects of effective and ineffective communication. Effective communication derives from clear and concise language, mutual respect, an understanding of professional roles, positive body language, pleasant tone-of-voice, and professionalism. With the use of positive communication, nurses and doctors are more likely to collaborate with one-another, respect each other, and form healthy relationships. Patients and family members are likely to pick up on the relationships among their care team, emphasizing the importance of healthy communication.

It is indicated that further research needs to be developed concerning specifically what errors are being as a result of miscommunication, and what forms of disruptive communication are being seen. A fair amount of research has been developed on the benefits of effective communication in the work environment, but it would be interesting to validate how often disruptive communication is reported in the workplace, and how destructive it can be. There have been proven ties between face-to-face communication and positive outcomes. Therefore, methods of increasing face-to-face interaction between healthcare providers must be explored further. Gaining perceptions of those within the interdisciplinary team can be utilized for educational purposes, providing insight into issues within the workplace. Bringing up the importance of

communication and acknowledging disruptive behavior can push healthcare providers and hospital administrators to strive for a healthy work environment, leading to positive outcomes.

The results of this literature review supported the author's belief that new communication techniques need to be implemented in nursing school and medical school curriculum. Each member of the interdisciplinary team needs to be aware of communication styles and techniques to improve the quality and safety of patient care. Healthcare providers who can communicate effectively create better patient outcomes, a perception of professionalism, mutual respect, all which leads to an increase in job satisfaction.

CHAPTER III

Methodology

Communication is a vital skill that every healthcare professional should possess. When healthcare professionals communicate effectively, care is delivered safely and efficiently. However, when communication is disruptive, healthcare professionals have reported dissatisfaction, misinterpretation, medication errors, and mortalities as a result of disruptive communication. The purpose of this project is to identify the type and level of disruptive communication at select Midwestern healthcare facilities in order to develop a program to teach nurses how to manage disruptive behavior. This chapter will discuss the designs of the scholarly project by outlining the sampling process, describing the demographics, and examining the instrument to be used as well as potential statistical analysis methods.

Project Design

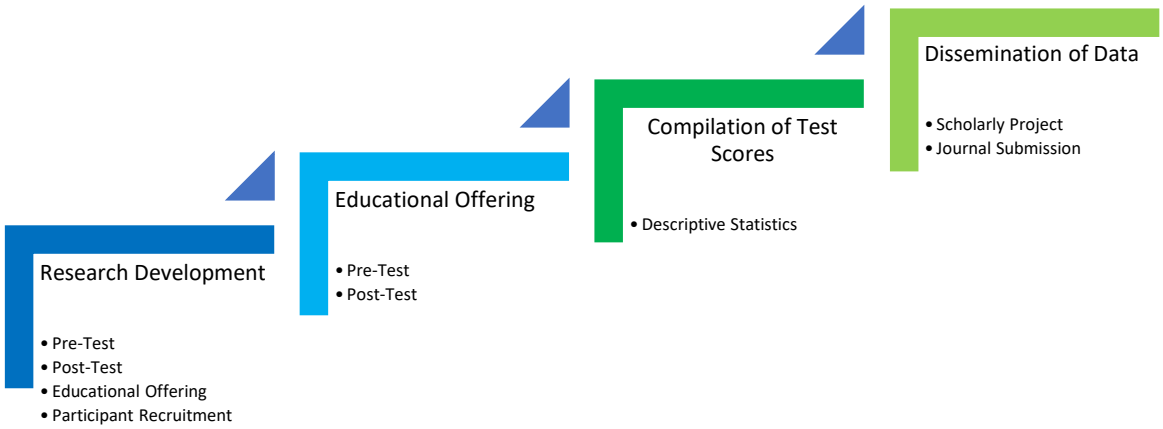
A mixed-method descriptive research design was utilized to measure communication methods, outcomes, and satisfaction among nurses. It was used to determine if discussing communication methods and techniques through an educational offering will improve nurses' level of confidence in managing disruptive behavior. The information from this study will help educators and leaders prepare nurses, nurse

practitioners, and doctors by educating and training them on the importance of effective communication and advocacy.

The project utilized a one-group pre-test/post-test design focused on nurses' confidence level in managing disruptive behavior. The chosen method of data collection was selected to yield information comparing the difference between pre-test and post-test scores after receiving education over disruptive communication and communication techniques. The pre-test asked participants about disruptive communication in the workplace the participants have personally experienced and assessed their confidence level of managing disruptive communication. The post-test was available to the nurses immediately after finishing the educational offering. Understanding what types of disruptive communication nurses are experiencing and incorporating communication techniques into nursing education could potentially allow hospitals, clinics, and schools to adopt these methods, encouraging nurses to properly advocate for their patients and work constructively within the interdisciplinary team. A diagram detailing the project design can be found below.

Figure 2

Project Design



Project Site and Population

The surveys prepared by this author and agreed upon by the Doctor of Nursing Practice Scholarly Project Committee were administered to two different regional hospitals. A convenience sampling of registered nurses was used and was determined by the number of participants at each location. A PowerPoint presentation utilizing communication methods collected from scholarly peer-reviewed journal articles and nursing textbooks was be prepared by this author. It was given live online through Webex communication software at Hospital A, while the pre- and post-tests were distributed in the break room. The same PowerPoint presentation was sent via Health Stream to participants along with links to the pre- and post-test at Hospital B. All participants who viewed the educational offering received the pre-test and post-test. The inclusion criterion for the study will require that participants hold a valid RN license and work within the hospital setting. Participants must also be at least eighteen years of age and speak English

as their primary language. The study did not include vulnerable subjects including mentally disabled individuals, children, or prisoners. It did not discriminate against specific populations due to race, religion, or ethnicity. All surveys were answered confidentially, and confidentiality was maintained during the data coding process. Participants were ensured that they will not experience harassment or discomfort during the research study. There were minimal risks associated with the pre-test and post-test. The responses of the subjects remain confidential to prevent any risk of criminal or civil liability or to cause damage to their financial standing, employability, or reputation.

Participation in the educational opportunity was voluntary; no monetary compensation was provided. Individuals were invited to participate in the study and educational offering via email. Consent was obtained on online consent forms and provided before initiating the pre-test. After providing informed consent, participant data was obtained through the participant's completion of the surveys. The data was analyzed using descriptive statistics. To guarantee confidentiality, the collected information did not contain any participant identifiers and were anonymously provided using both Health Stream software and traditional handouts. Additionally, data from completed online questionnaires was coded by Health Stream and submitted online to the researcher only.

Ethical Considerations/Protection of Human Subjects

As stated above, participation in the study was solely voluntary. Due to the nature of the study, which involves a pre-test and post-test regarding sensitive information, unique experiences, and perceptions, the primary ethical concern was the potential identification of participants due to the survey response answers. Therefore, anonymity is imperative. Information was recorded and stored without any identifiers to maintain

obscurity. False information, such as the fabrication of events provided by participants was also concerning, potentially leading to the contamination of data. Finally, validity and reliability of a developed instrument can alter the data's statistical significance. This author will uphold the three basic principles of human subject protection: respect for persons, beneficence, and justice. IRB approval was obtained by this author before contacting participants and collecting data.

Instruments

The study utilized two formats to deliver surveys to obtain data—a pre-test survey and a post-test survey. One hospital's surveys were administered through an online format using Health Stream software. The other hospital completed the surveys anonymously with pen and paper. Both survey formats were the same, containing demographic data including age, gender, years of practice, and area of practice. They included open-ended, closed-ended, and Likert-scale questions. The pre-test included questions regarding the nurses' personal experience with disruptive communication, including narratives, and patient outcomes. While both surveys assessed nurses' confidence level in managing disruptive behaviors, the post-survey did not include questions regarding personal experience; instead, it focused on the educational outcomes. The quantitative data obtained from the surveys were analyzed using descriptive statistics.

A survey tool was developed for the study because a specific instrument for the study could not be found. However, the instrument was based on a previous study conducted by Rosenstein & O' Daniel (2005). In their study, perceptions of disruptive behavior among the interdisciplinary team were thoroughly assessed, addressing

outcomes, job satisfaction, and nurse retention. The study included nurse practitioners, doctors, and nurses. Using the Rosenstein & O' Daniel (2005) survey as a model, modifications were made, and a new expanded survey was created for this research study. The first several questions in the pre- and post-test addressed the participant's demographics. In the pre-test, the next set of questions addressed the "occurrence of disruptive behavior among nurses and doctors, the influence of gender, psychological and clinical variables and clinical outcomes, and respondent's comments" (Rosenstein & O' Daniel, 2005). The final group of questions in the pre-test and most of the post-test addressed the nurse's confidence in managing disruptive behavior. Both surveys included open-ended, closed-ended, and five-point Likert-scale questions. The study focused on the following research questions:

1. What type of disruptive behavior are nurses experiencing?
2. How frequently do nurses experience disruptive behavior?
3. What outcomes do nurses perceive result from disruptive behavior?
4. Do nurses perceive there is a relationship between communication and job satisfaction?
5. Is there a relationship between the frequency of disruptive behavior and the nurse's perception of the relationship between communication and job satisfaction?
6. What is the nurse's level of confidence in managing disruptive behavior before an educational offering?
7. What is the nurse's level of confidence in managing disruptive behavior after an educational offering?

Content Validity

The survey instrument was developed by the researcher; therefore, instrument validity needed to be determined. To determine content validity, the survey instrument was reviewed by a board of Pittsburg State University Irene Ransom Bradley School of Nursing faculty members. Faculty members were provided the survey, and provided feedback utilizing their previous experience within the field of nursing. Changes were made based on feedback.

Analytical Methods

Descriptive statistics were used to describe demographic data, such as the number of participants, gender, age, and confidence. Correlational statistical analysis was performed on frequency of disruptive behavior and nurse job satisfaction.

Procedure

The proposal defense took place by March 30th, 2020 with the project committee consisting of two Pittsburg State University Irene Ransom Bradley School of Nursing faculty members and one Pittsburg State University Department of Communications faculty member. Upon proposal approval, the proposal was sent to Irene Ransom Bradley School of Nursing and Pittsburg State University's IRB committee for approval. The IRB form, Research Involving Human Subjects, was completed by the author and approved by Pittsburg State University in early January 2021. The educational offering took place January of 2021. A voice-over PowerPoint presentation was used at one hospital and live online presentation was given at the other. Before the presentation, participants at both hospitals were asked to complete a pre-test with questions regarding demographics, experience with and perceptions of disruptive behavior, and confidence levels in

managing disruptive behavior. After finishing the educational offering, the participants completed a post-test, focusing on demographics and confidence levels in managing disruptive behavior. Surveys at Hospital A were available for nurses to pick up and fill out anonymously in the break room. Participants were instructed to fill out the questionnaire, and leave it face-down in a drop box. The researcher collected the submissions every Friday for two weeks. Although the traditional route of gathering data is not as secure as advanced online sources, it still allowed anonymity. Hospital B posted the pre-questionnaire on Health Stream for the nurses to complete. The data was disseminated, statistically analyzed, and the findings were reported.

The research project consisted of a pre-test, educational offering, and post-test to assess experiences of disruptive behaviors, outcomes from disruptive behaviors, nurse satisfaction levels, and confidence-levels while addressing disruptive behaviors. Consent was obtained from participants by giving them with the pre-test through Hospital A, and before taking the online pre-test at Hospital B. The pre-test was developed and administered anonymously in the breakroom and using Health Stream, an education software available online. Health Stream allowed for convenient online delivery of the assessment tools to participants and allowed them to complete the assessment on their own time. Data obtained by the researcher did not contain any participant identifiers, allowing for the protection of participants. The pre- and post-test were left in the breakroom by the researcher and was available to nursing staff in the emergency, med-surg, and surgery departments at Hospital A. The pre- and post-test was available on Health Stream for obstetrics, surgical, med-surg, emergency department, and the intensive care unit at Hospital B. The data was reviewed and analyzed by the researcher

using descriptive statistical analysis. After completion of the pre-test, participants were invited to participate in the educational offering.

The educational offering was available to all departments at both hospitals, offered to both—participants, and non-participants. It was provided through a PowerPoint presentation available through Health Stream at Hospital B. At Hospital A, a live presentation with the same PowerPoint was provided online through a communication service called Webex. Therefore, participants at both hospitals could engage in the research study at home or at the hospital with access to wi-fi and to a computer. Both participating facilities had multiple computers and educational centers available to their nursing staff. A review of evidence-based communication techniques and confidence-building strategies was provided within the PowerPoint. A post-test was provided immediately following the educational offering. Like the pre-test, the post-test was available in the break room at Hospital A and on Health Stream for Hospital B. The data from the survey was analyzed using descriptive statistics.

Budget

There was no cost incurred for the creation and distribution of the surveys. The student utilized resources from the Pittsburg State University Irene Ransom Bradley School of Nursing as indicated.

Strengths and Weaknesses of the Project

Strengths of the project include the pre-test acting as a control, comparing the sample's pre- and post-test scores to determine if the participants feel more confident in their communication methods. Weaknesses of the study include human error and false information that may be provided by participants, affecting the validity of the research.

Nurses are the only portion of the interdisciplinary team who are invited to provide insight on disruptive behavior. This is concerning because disruptive behavior is experienced across the spectrum of healthcare providers.

Summary

A descriptive mixed-methods research design was used in this scholarly project through convenience sampling from two small hospitals in the Midwest. Descriptive statistics was evaluated upon review of the research. A review of data analysis was used to determine whether registered nurses feel more confident in managing disruptive behavior after learning and reviewing communication techniques. It also assessed what types of disruptive behaviors nurses are experiencing, what outcomes are manifested from disruptive behavior, and how it affects job satisfaction among nurses. Evaluation of the research outcomes occurred, utilizing a one group pre-test-post-test method.

CHAPTER IV

Evaluation Results

Purpose

The purpose of this study was to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators about disruptive communication. Data was collected with the goal of assessing disruptive behaviors, disruptive behavior's relationship to job satisfaction, and nurse confidence levels in managing disruptive behavior. Seven questions were developed to guide the project:

1. What type of disruptive behavior are nurses experiencing?
2. How frequently do nurses experience disruptive behavior?
3. What outcomes do nurses perceive result from disruptive behavior?
4. Do nurses perceive there is a relationship between communication and job satisfaction?
5. Is there a relationship between the frequency of disruptive behavior and the nurse's perception of the relationship between communication and job satisfaction?
6. What is the nurse's level of confidence in managing disruptive behavior before an educational offering?

7. What is the nurse's level of confidence in managing disruptive behavior after an educational offering?

We can determine if nurses could benefit from communication education to understand better communication styles and how to confront disruptive behavior through data analysis. In this chapter, there will be a discussion of the population studied and analysis of data collected in relation to the project's purpose.

Sample

Two questionnaires and an educational offering were provided at two rural hospitals in the Midwest. Nurses from the Medical-Surgical, Emergency, and Surgical Departments were invited to participate at both hospitals. Hospital B had the addition of Obstetrics and Intensive Care nurses. A convenience sampling of registered nurses was utilized and determined by the number of participants at each location. Once approval was granted through Hospital A, Hospital B, and Pittsburg State University, data was collected within two weeks in the month of February of 2021. Only registered nurses were asked to participate in the research study. The study did not include vulnerable subjects including mentally disabled individuals, children, or prisoners. It did not discriminate against specific populations due to race, religion, or ethnicity. At Hospital A, ten nurses participated in the pre-education questionnaire, while only five nurses participated in the post-education questionnaire. Hospital B had 41 participants in the pre-and post-education questionnaire. A total of 51 nurses participated in the pre-questionnaire, and 46 nurses contributed to the post-education questionnaire. In both the pre-and post-questionnaires, only two males participated in the study. The majority of the nurses in both studies had greater than 15 years of experience, worked days, and worked

on the Medical-Surgical unit, as portrayed in Tables 1-3 below. Descriptive statistics were used to calculate frequencies and percentages.

Table 1.

Total Years of Experience

	Pre-Questionnaire		Post-Questionnaire	
Year	Frequency (N=51)	Percent (%)	Frequency (N=47)	Percent (%)
0-1 Year	3	5.9	2	4.3
2-5 Years	2	3.9	1	2.1
5-10 Years	16	31.4	13	27.7
10-15 Years	5	9.8	6	12.8
Greater than 15 Years	25	49	24	51.1
Missing			1	2.1
Total	51	100	47	100

Table 2.

Current Unit

	Pre-Questionnaire		Post-Questionnaire	
	Frequency (N=51)	Percent (%)	Frequency (N=47)	Percent (%)

Medical/Surgical/General	22	43.1	17	36.2
Intensive Care	1	2	1	2.1
Outpatient Clinic	5	9.8	5	10.6
Emergency Department	5	9.8	5	10.6
Obstetrics	4	7.8	4	8.5
Surgery	14	27.5	14	29.8
Missing			1	2.1
Total	51	100	47	100

Table 3.

Current Shift

	Pre-Questionnaire		Post-Questionnaire	
	Frequency (N=51)	Percent (%)	Frequency (N=47)	Percent (%)
Days	40	78.4	37	78.7
Evenings	1	2	1	2.1
Nights	10	19.6	8	17
Missing			1	2.1
Total	51	100	47	100

Description of Key Terms/Variables

Four key variables were evaluated throughout the project. Disruptive behavior is an independent variable that could lead to adverse outcomes. Therefore, the goal was to measure outcomes (if any) nurses perceive or experience and how often they experience these outcomes. Job satisfaction, outcomes, and confidence levels are all dependent variables that stem from disruptive behavior. Therefore, it is essential to measure all these variables thoroughly and evaluate if there is a relationship between the independent and dependent variables.

Analysis of Project Questions

This project was performed to answer seven questions. Therefore, to ensure thoroughness, each question will be answered individually.

The first question asks, "What type of disruptive behavior are nurses experiencing?" Participants were given five specific statements and asked to state if they were true or false. These statements included, "A nurse practitioner or doctor has hung up the telephone on me", "A nurse practitioner or doctor has yelled at me", "A nurse practitioner or doctor has belittled me", "A nurse practitioner or doctor has cursed at me", and "A nurse practitioner or doctor has asked me not to call back about a patient situation I found concerning". A total of 51 (N=51) participants responded. Descriptive statistics calculating frequency, percent, and mean were used for the table below (Table 4). The majority of the nurses responded "True" to experiencing "Hung up on phone" (51%), "Yelled" (72.5%), and "Belittled" (68.6%). The majority of nurses answered "False" to "Cursed At" (58.8%) and "Asked Not to Call Back" (76.5%).

Table 4

Types of Disruptive Behavior

		Frequency (N=51)	Percent (%)	Mean
	True	26	51	
	False	25	49	
Hung up Phone	Total	51	100	1.49
	True	37	72.5	
	False	14	27.5	
Yelled	Total	51	100	1.27
	True	35	68.6	
	False	16	61.4	
Belittled	Total	51	100	1.31
	True	21	41.2	
	False	30	58.8	
Cursed At	Total	51	100	1.59
	True	12	23.5	
Asked Not to Call	False	39	76.5	
Back	Total	51	100	1.76

Question two examined, “how frequently do nurses experience disruptive behavior?” To answer this question, this author asked the participants, “about how often do you witness disruptive behavior in the workplace?” To answer this question, data was derived utilizing descriptive statistics. Results stated that 2% of the subjects witnessed disruptive behavior daily, 25.5% weekly, 17.6% monthly, 3.9% annually, and 51% stated

almost never (Table 5). The mean was calculated as 3.76, meaning an average rating of "monthly" Descriptive statistics were utilized to calculate frequency, percent, and mean.

Table 5.

How Often Disruptive Behavior is Witnessed

	Frequency (N=51)	Percent (%)
Daily	1	2
Weekly	13	25.5
Monthly	9	17.6
Annually	2	3.9
Almost Never	26	51
Total	51	100

The third research question inquires, "What outcomes do nurses perceive result from disruptive behavior?" Nurses were asked to answer true or false to two quantitative questions measuring outcomes. The first question regarding outcomes states, "A patient was placed in a dangerous situation due to disruptive communication. (i.e. yelling, belittling, hanging up the phone, etc.). Of the respondents, 23.5% stated "true" while 76.5% answered "false" (Table 6). The second question included, "I have witnessed a patient experience harm due to disruptive communication. (i.e. yelling, belittling, hanging up the phone, etc.). A total of 21.6% of the respondents indicated "true" while 78.4% said "false" (Table 7). Descriptive statistics were used to calculate frequency, percent, and mean.

Table 6.

A Patient was Placed in a Dangerous Situation due to Disruptive Communication

	Frequency (N=51)	Percent (%)
True	12	23.5
False	39	76.5
Total	51	100

Note. The mean is 1.76.

Table 7.

A Patient Experienced Harm due to Disruptive Communication

	Frequency (N=51)	Percent (%)
True	11	21.6
False	40	78.4
Total	51	100

Note. The mean is 7.6.

The participants were immediately asked a qualitative follow-up question to analyze a specific outcome that the nurse had experienced. They were asked, "Please explain how the patient was harmed or placed in a dangerous situation resulting from disruptive communication." Ten nurses from Hospital B and four nurses from Hospital A answered this question (N=14). Two participants explained that two patients "Had to be taken back to surgery." and that it "Could have been avoided." Five responses stated the physician dismissed their concerns. Responses included, "Refused to listen to RN, [the patient] coded." "Made me feel like I was seeing something that wasn't there; had me second-guessing my skills as a nurse and made me fearful to call them back." "The doctor told me that they were too busy to deal with this and this was not real, and they

had real sick people to attend to." "Provider on call at night but gave minimal medication because the patient was not his." Three respondents stated that doctors had yelled at staff, describing "Physician was cursing and yelling in frustration during a YAG procedure… patient verbalized feeling belittled and said, 'he was cussing at me.' There could have been injury to the eye with the laser"-"when a surgeon starts yelling during a surgery I fill it puts the patient at risk due to loss of control and focus from the Dr." One respondent stated, "I have witnessed nurses afraid to call about concerns because they had been belittled by a physician before." One respondent said, "[patients] left in small town hospitals. ICU [patients] admitted creating hardships for inappropriate admits". One nurse stated, "Would rather not say." Another respondent stated, "I have not witnessed [a] patient in this situation." One participant stated, "I have witnessed nurses afraid to call about concerns because they had been belittled by a physician before."

The fourth research question asked, "Do nurses perceive there is a relationship between communication and job satisfaction?" Participants were asked to rate "Communication between caregivers affects job satisfaction" on a Likert Scale to assess the level of job satisfaction. The majority of the respondents (96.1%) stated "agree," while the rest of the respondents (3.9%) stated "somewhat agree" (Table 8). Descriptive statistics were utilized to calculate frequency, percent, and mean.

Table 8.

Level of Satisfaction

	Frequency (N=51)	Percent (%)
Agree	49	96.1
Somewhat Agree	2	3.9

Neutral	0	0
Somewhat Disagree	0	0
Disagree	0	0
Total	51	100

Note: The mean is 1.04

The fifth research question inquires, "Is there a relationship between the frequency of disruptive behavior and the nurse's perception of the relationship between disruptive behavior and job satisfaction?" A one-way ANOVA was conducted to compare how often nurses witness disruptive behavior and the nurse's perception of communication's effect on job satisfaction. There was a significant effect of the frequency of disruptive behavior on the nurse's perception of communication's effect on job satisfaction [$F(46, 4) = 1.558$, $p = 0.202$]. Due to the limited number of cases, the author could not conduct a post hoc test. The results from the one-way ANOVA test are displayed below.

Table 9.

Perception of Disruptive Behavior's Effect on Job Satisfaction

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	0.229	4	0.057	1.558	0.202
Within Groups	1.692	46	0.37		
Total	1.922	50			

The sixth question asks, “What is the nurse’s level of confidence in managing disruptive behavior before an educational offering?” To answer this research question, participants were asked to rate their confidence levels utilizing a Likert Scale. Descriptive statistics calculating frequency, percent and mean were used to determine the results (Table 9). The majority of the respondents (39.2%) replied “Somewhat Confident”, while 27.5% chose “Confident”, 19.6% “Neutral”, 11.8% “Somewhat Unsure”, and 2% “Unsure” (N=51).

Table 10.

Confidence Level Before Educational Offering

	Frequency (N=51)	Percent (%)
Confident	14	27.5
Somewhat Confident	20	39.2
Neutral	10	19.6
Somewhat Unsure	6	11.8
Unsure	1	2
Total	51	100

Note: The mean is 2.22.

The final question asks, “What is the nurse’s level of confidence in managing disruptive behavior after an educational offering?” In the post-questionnaire, participants were asked, again, “What would you rate your confidence level in addressing disruptive behavior?” Again, participants utilized a Likert Scale to rate their confidence levels. Descriptive statistics were utilized to calculate frequency, percentage, and mean (N=47).

Of the respondents, 34.8% rated their confidence levels “confident”, 39.1% “Somewhat Confident”, 17.4% “Neutral”, and 8.7% Somewhat Unsure”. None of the respondents stated “unsure”. Results are displayed in the table below (Table 10).

Table 11.

Confidence Level After Educational Offering

	Frequency (N=47)	Valid Percentage (%)
Confident	16	34.8
Somewhat Confident	18	39.1
Neutral	8	17.4
Somewhat Unsure	4	8.7
Unsure	0	0
Total	46	100
Missing	1	

Note: The mean is 2.00

Knowledge Gain

This study utilized a Mixed-Method design to assess nurse’s insight, experience, and confidence levels pertaining to disruptive communication. Quantitative data reflected findings related to how often disruptive behavior is witnessed, what type of disruptive behaviors are exhibited, if satisfaction levels are affected by disruptive behavior, and how confident nurses are confronting disruptive behaviors. Qualitative data provided personal insight from the participants’ experience regarding how disruptive communication can lead to negative outcomes.

Additional Statistical Analyses

After answering the seven research questions, additional statistical analyses were performed to support the statistical evidence and report stimulating findings for further research. A paired samples test was performed to compare the pre-and post-questionnaire findings regarding nurse's confidence levels when addressing disruptive behavior. The results of the individual pre- and post-education questions regarding confidence levels were displayed above. A paired test was used to determine if the confidence levels were truly elevated after learning how to effectively confront disruptive behavior. According to the paired t-test, the p-value is equal to 0.058, meaning that the findings were statistically significant. Figure 1 displays confidence levels before the educational offering, while Figure 2 shows an increase in confidence levels after the educational offering.

Figure 3

Confidence Levels before Educational Offering

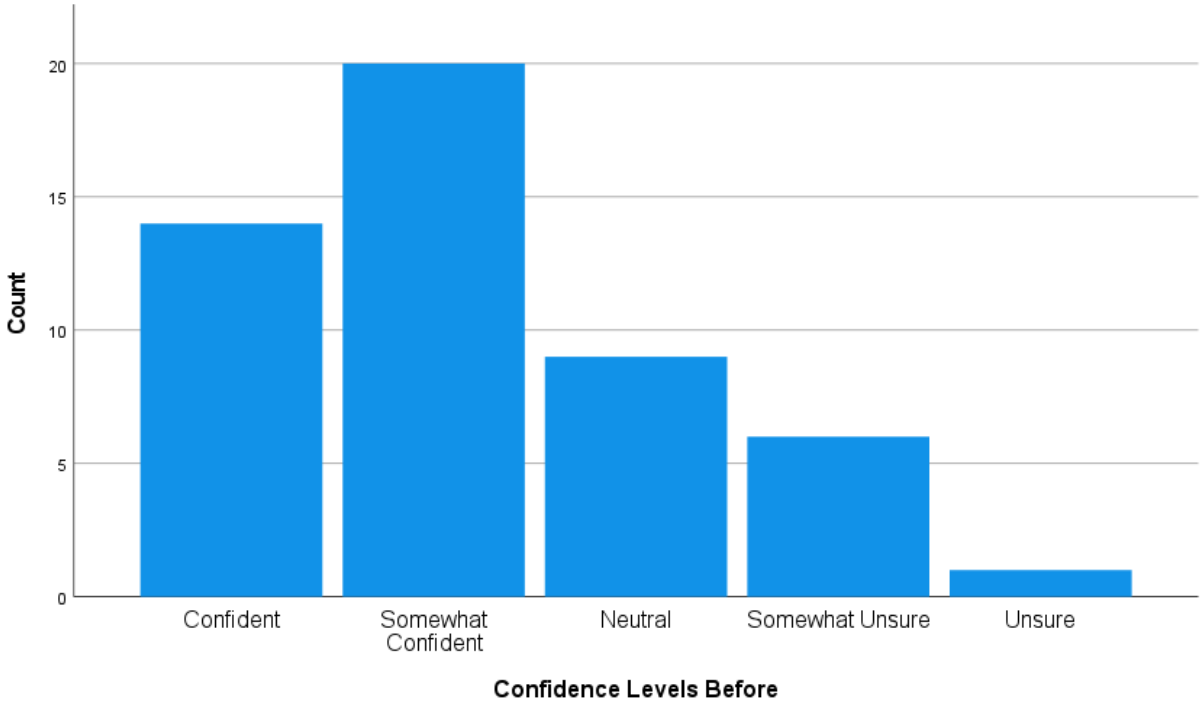
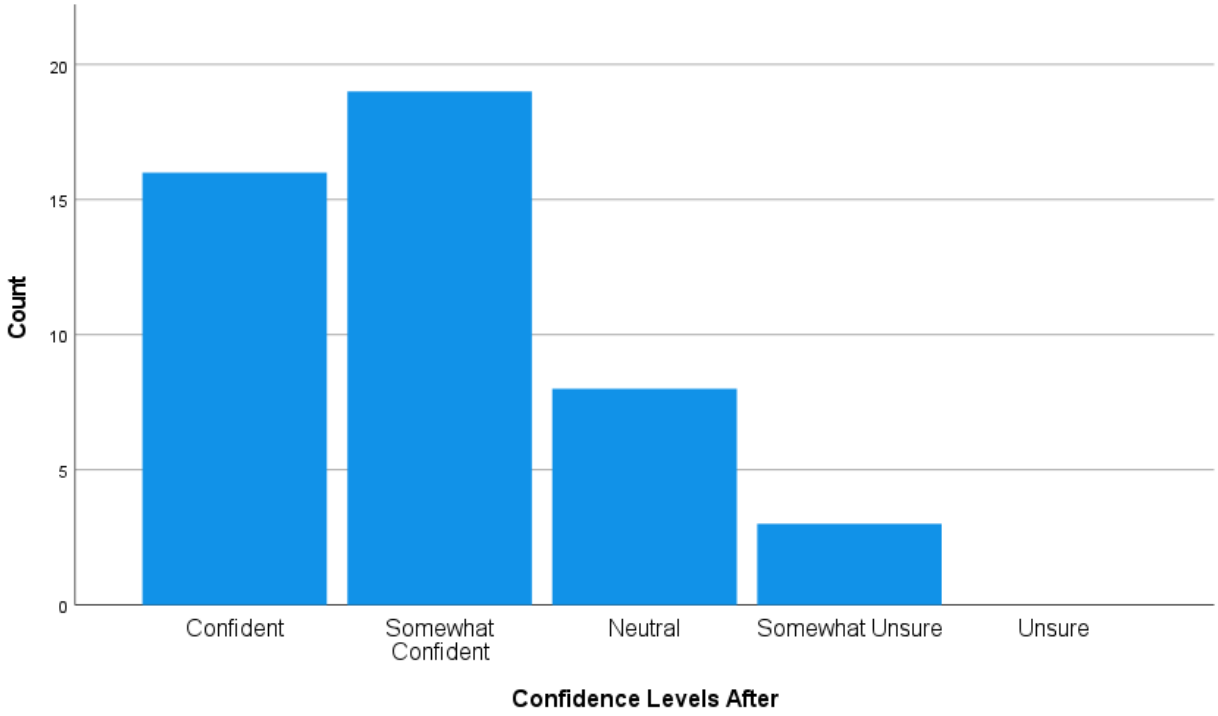


Figure 4

Confidence Levels after Educational Offering



Another interesting finding within the research was the participants' responses to the question, "I feel that education regarding positive communication needs to be included in continuing education for nurses, nurse practitioners, and Doctors." in the pre- and post-education questionnaires. Most of the respondents in the pre- (80.4%) and post- (87%) questionnaire agreed with the statement. None of the participants responded, "Somewhat Disagree" or "Disagree". Descriptive statistics were utilized to calculate mean, frequency, and percentage of the responses. See Table 11 for results.

Table 12.

Education Needs to be Included in Continuing Education Responses

	Pre-Education	Post-Education

	Frequency (N=51)	Percentage (%)	Frequency (N=46)	Percentage (%)
Agree	41	80.4	40	87
Somewhat Agree	9	17.6	5	10.9
Neutral	1	2	1	2.2
Somewhat Disagree	0	0	0	0
Disagree	0	0	0	0
Total	51	100	46	100
	Mean =1.22		Mean= 1.15	

Summary

Results from the data analysis revealed findings in the study that were related to the purpose of the research. The purpose of this study was to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators of disruptive communication. Two questionnaires were utilized to gather quantitative and qualitative data before and after and education offering.

When participants were asked what type of disruptive behavior they have experienced within the workplace, the majority of nurses stated they were yelled at (72.5%), belittled (68.6%), and hung up on (51%). When calculating the frequency of disruptive behavior experienced, the bulk (51%) of the participants stated "almost never," followed by 25.5% of them reporting "weekly." Although most of the subjects said they had not witnessed a patient being placed in a dangerous situation or experienced harm from disruptive communication, some chose to share their experiences when they witnessed this. Harmful outcomes include patients returning to surgery, nurses questioning their skills, and even patients coding. A total of 96.1% of participants agreed that communication between caregivers affects job satisfaction. After receiving education regarding disruptive communication and proper communication techniques, confidence levels rose significantly.

The rationale for this research was to argue the need for additional education regarding communication techniques within the workplace and practice/policy change to support better communication styles. With this analysis of data, it can be concluded that these changes are warranted. Further discussion about the implications of the data will continue in Chapter V.

CHAPTER V

Discussion

The purpose of this study was to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators of disruptive communication. Understanding the consequences of disruptive communication can help educators articulate the need for training in conflict management and therapeutic communication methods. It can also aid healthcare providers to be more conscious of their behavior in the professional setting. The goal is that effective communication techniques will lead to increased job satisfaction for nurses, higher nurse retention rates, and better patient outcomes.

Relationship of Outcomes to Research

Seven research questions were developed and tested for this scholarly project. The first research question tested was, "what type of disruptive behavior are nurses experiencing?" The pre-questionnaire used five specific questions utilizing a true-false format of answers to collect data. These questions included:

- A nurse practitioner or doctor has hung up the telephone on me.
- A nurse practitioner or doctor has yelled at me.
- A nurse practitioner or doctor has belittled me.
- A nurse practitioner or doctor has cursed at me.

- A nurse practitioner or doctor has asked me not to call back about a patient situation I found concerning.

The majority of the nurses responded "True" to experiencing "Hung up on phone" (51%), "Yelled" (72.5%), and "Belittled" (68.6%). These results depict the forms of disruptive behaviors nurses are experiencing. Researchers, educators, and policymakers need to understand the behaviors are in order to focus on these issues when addressing disruptive communication.

The second question evaluates how frequently nurses experience disruptive behavior. The majority (51%) stated, "Almost Never," followed by 25.5% answering "Weekly," 17.6% "Monthly," and 3.9% "Annually," and 2% "Daily." The frequency of the behavior emphasizes how relevant the issue truly is. If most nurses responded "Daily" versus "Almost Never," the problem would be ubiquitous and would need to be addressed immediately. Remarkably, even though most nurses stated, "Almost Never," the second most prevalent response was "Weekly," which is quite frequent, therefore, increasing the relevance of the issue.

The third question was, "What outcomes do nurses perceive result from disruptive behavior?" This question assesses if nurses have witnessed harmful situations and outcomes and specifically asks nurses to share their experiences with the researcher. Remarkably, 23.5% of respondents have seen a patient being placed in a dangerous situation, and 21.6% witnessed actual harm to a patient. A total of 14 participants (27%) shared their experiences. Of the experiences shared, most (five) were related to doctors/nurse practitioners dismissing nurses' concerns. This led to a patient coding, a nurse second-guessing his/her skills, and upset patient family members. Three

respondents shared instances where patients were in danger because the physician/NP was yelling. Two participants described patients going back to surgery because of disruptive behaviors. One respondent described patients being admitted and kept in rural hospitals when they need a higher level of care. Another volunteer stated they have witnessed other nurses display apprehension when calling doctors/nurse practitioners for a patient concern. Knowing the frequency and type of negative outcomes fuels the need for change, as well as education for healthcare providers. The main goal of healthcare is safety and quality of care. If research proves a relationship between disruptive behavior and a lack of patient safety, stakeholders such as policymakers, educators, and health institutions will be more motivated for change.

The fourth question examines nurse's perception of communication's relationship with job satisfaction. Participants were asked to rate "Communication between caregivers affects job satisfaction" on a Likert Scale to assess the level of job satisfaction. The majority of the respondents (96.1%) stated: "agree." Job satisfaction affects retention rates. Nurses are already experiencing a shortage; therefore, low retention rates exacerbate the issue. Thus, nursing leaders need to know what affects job satisfaction and what they can do to improve it. This question shows how important proper communication and behaviors are for retaining nurses.

The fifth question queries, "Is there a relationship between the frequency of disruptive behavior and the nurse's perception of the relationship between disruptive behavior and job satisfaction?" A one-way ANOVA test was conducted to compare how often nurses witness disruptive behavior and the nurse's perception of communication's effect on job satisfaction. There was a significant effect of the frequency of disruptive

behavior on the nurse's perception of communication's effect on job satisfaction [F(46, 4) = 1.558, p = 0.202]. Due to the limited number of cases, the author could not conduct a post hoc test. These results suggest that the frequency of disruptive communication can influence the nurse's perception of disruptive behavior's effects on job satisfaction. For example, if a nurse rarely experiences disruptive behavior within the workplace (such as annually) they are more likely to believe that disruptive behavior does not affect job satisfaction. Although frequency may influence perception, nursing leaders need to pay attention and listen to their nurses when they report any dissatisfaction within the workplace.

The sixth question asks, "What is the nurse's level of confidence in managing disruptive behavior before an educational offering?" The majority (39.2%) of participants responded, "Somewhat Confident." A total of 27.5% chose "Confident," 19.6% "Neutral," 11.8% "Somewhat Unsure," and 2% stated "Unsure." This question allowed this author to compare the pre-and post-questionnaire answers to evaluate the educational offering's effectiveness. This, too, validates the need for continuing education regarding effective communication.

The final question asks, "What is the nurse's level of confidence in managing disruptive behavior after an educational offering?" Like the previous question, this question assesses the effectiveness of the educational offering. Of the respondents, 34.8% rated their confidence levels "confident," 39.1% "Somewhat Confident," 17.4% "Neutral," and 8.7% Somewhat Unsure". None of the respondents stated, "Unsure." Evidence showed that confidence levels raised after the educational offering, deeming the curriculum as valid. For instance, data shows that the amount of nurses who marked

“confident” increased from 19.6% to 34.8% and the number of respondents who stated “unsure” in the pre-questionnaire (2%) declined to 0% in the post-questionnaire.

Observations

The results from this study indicate the need for additional education regarding communication and proper communication techniques. As stated before, patient safety and quality of care are the essential components of healthcare. As found in the research, disruptive behaviors hinder safety and quality of care. Therefore, the need for change is validated, whether it is education, policy change, or institutional policies. An interesting finding within the research was the participants' responses to the question, "I feel that education regarding positive communication needs to be included in continuing education for nurses, nurse practitioners, and Doctors." in the pre-and post-education questionnaires. A total of 80% of respondents answered "agree" in the pre-questionnaire. In comparison, the number of respondents rose to 87% in the post-questionnaire. This indicates an agreeance among the participants that continual education needs to be implemented.

Evaluation of Theoretical Framework

The theoretical framework, CAT was applied to the research project through nurse education. CAT observes the human tendency to adjust their behavior to match their interaction with others. The nurses were educated on the usage and effects of verbal and non-verbal cues. Verbal cues include word choice and communication styles, such as passive, passive-aggressive, aggressive, and assertive communication. Non-verbal cues include the usage of space, body language, facial expression, gestures, eye contact, and vocal expression. In the educational offering, they were encouraged to use assertive

communication while maintaining aware of their non-verbal cues to effectively and respectively exchange information with a doctor or nurse practitioner.

SET is a social psychological perspective that explains that reciprocity and behaviors are based on a cost-benefit analysis. For example, a doctor is more likely to comply with a nurse's request if the nurse communicates their needs in a polite, respectful way. While verbal and non-verbal cues can help the nurses obtain what they want/need from the nurse/doctor relationship, the education followed SET by emphasizing the importance of following the SBAR format when discussing concerns with a physician. Using SBAR helps health-care providers avoid long narrative descriptions and ensures that facts are shared with the doctor or nurse practitioner. The SBAR format also allows for the nurse to clearly state what they expect to gain from the conversation. Utilizing concise language is important, for in a study performed by McCaffrey et al. (2010), doctors reported they preferred to spend little time on communication, and they expect nurses to anticipate the doctor's needs and take orders correctly.

The pre- and post-education questionnaires allowed for the evaluation of utilizing CAT and SET as the framework for the educational offering. To evaluate the nurses' confidence level utilizing SBAR for SET, they were asked to rate the statement, "I feel comfortable utilizing the Situation Background Assessment Recommendation (SBAR) format when communicating with a nurse practitioner or physician" on a Likert-Scale. The scores were consistent, with 78.4% stating "agree in the pre-questionnaire, while 78.3% agree in the post-questionnaire. While there is consistency in responses between the pre-and post-questionnaires, it is

remarkable that only 2% of the respondents replied “Unsure” in the pre-questionnaire, none of them replied “Unsure” in the post-questionnaire. To evaluate the curriculum based on CAT and SET, nurses were asked to rate, “What would you rate your confidence level in addressing disruptive behavior” on a Likert-Scale. A total of 27.5% of nurses responded “Confident” in the pre-questionnaire, raising to 34.8% in the post-questionnaire. The rise in confidence levels in using SBAR and addressing disruptive behaviors seen in the post-questionnaire validates the efficacy of the curriculum based on CAT and SET.

The theoretical framework, "The Schutzian Lifeworld Phenomenological Orchestra Study," performed by Valerie Malhotra (1981), was applied to this scholarly project. This theory compares the healthcare team to an orchestra. It describes how each member of an orchestra provides their knowledge, experience, and talents to contribute to the orchestra as a whole. To fully function as an orchestra, musicians have to know their roles and anticipate everyone else's in the orchestra. Like musicians in an orchestra, each health team member must utilize quality verbal and non-verbal communication to understand each member's contribution to the same goal. To provide the highest quality of care, nurses and doctors must communicate effectively to achieve the desired outcome.

The pre-and post-education questionnaires assess relationships between disruptive behavior and its effects on the interdisciplinary team, patient outcomes, and job satisfaction levels. Therefore, it is evaluating if disruptive communication negatively influences the effectiveness of the healthcare team. The questionnaire also provides insight into nursing perceptions of physician behavior changes regarding understanding the nurse's role by asking, "I feel that if doctors properly understand the nursing role, they

would respect nurses more." In both—the pre- (49%) and post-questionnaires (56.5%), the majority of the respondents replied: "agree." This supports the theory's belief that healthcare members need to understand each other's roles to function properly. Future studies should be performed to verify that understanding each other's roles can improve respect and communication to prove the theory.

Evaluation of the Logic Model

In the first chapter, a logic model was established to display the relationship between disruptive communication, adverse outcomes, and nursing education implementation. The logic model shows the transition from the need, development, implementation, and desired education outcomes regarding communication. This scholarly project closely followed the logic model. First, it analyzed the prevalence of disruptive communication and what outcomes are produced through a pre-education questionnaire. Education regarding disruptive communication and effective communication was then provided through a PowerPoint presentation, utilizing information gathered through the literature review. Afterward, the participants took a post-education questionnaire, rating their beliefs about communication and confidence levels when confronting disruptive communication. Since this study was not longitudinal, it is challenging to assess motivation for change, respect and understanding, active listening, and effective, clear communication. However, perceptions did change after the educational offering was given. Perceived confidence levels when addressing disruptive behavior rose after receiving the educational offering. The respondents also validated the need for continuing education regarding communication techniques. Even with a time limitation, the logic model proved useful and appropriate for this scholarly project.

Limitations

Time was a factor in data collection and analysis. The information was collected and analyzed independently by this author. Additional time would allow the researcher to re-evaluate the research subjects at least three months after the educational offering. This would determine if values and beliefs are consistent after completing the questionnaires and education. The collection of data lasted two weeks at Hospital B and four weeks at Hospital A. If there had been more time for data collection, more nurses may have participated in the research. Another weakness was the limited sample size—a total of 51 nurses for the pre-questionnaire and 46 nurses for the post-questionnaire. Finally, the nurses who participated in the pre-questionnaire were the same ones who participated in the post-questionnaire Hospital B, while it is unknown if the subjects were the same for the Hospital A questionnaires. This is due to the format of how the research project was distributed at each hospital. Hospital B utilized Health Stream, formatted in a quiz-like fashion. The subjects were not allowed to proceed to the "next step" until they finished the pre-requisites. Therefore, the results were consistent, with a total of 41 nurses participating in both surveys. ACRH used a more traditional style of collecting research data, utilizing a pen-and-paper format of questionnaires. This format led to the discrepancy of sample sizes in the pre-and post-questionnaires. A total of ten nurses filled out a pre-questionnaire, while only five filled out the post-questionnaire. Using a method such as Health Stream at both hospitals can prevent inconsistencies and provide more accurate results. The inconsistency of the number of participants from each hospital can also be related to the number of nurses employed at each hospital. Hospital A has less than 50 nurses on staff, while Hospital B employs at least 100 nurses. The difference in

nurse population between the two hospitals explains the variation between the number of participants at each hospital. Performing the study at two hospitals with similar sizes of nursing staff could prevent this discrepancy.

Another limitation found within the study was the majority of respondents work day-shift. Different shifts may have different frequencies and occurrences with disruptive behaviors. In the pre-questionnaire, 40 participants reported working day shift, while ten work nights and one works evenings. The post-questionnaire also had mostly day shift nurses (N=37), while eight nurses work nights and one works evening shifts. The collected data determining years of experience may have also been skewed, because it may be likely that day shift nurses have more experience. According to Ritonja et al. (2019) "While the evidence is unclear regarding age and shift work tolerance, there is biologic plausibility for poorer shift work tolerance at older age" (p. 204). Statistics reflects this by showing that 49% (N=25) of respondents have over 15 years of experience in the pre-questionnaire with 52.2% (N=41) in the post-questionnaire. The respondents' average experience in both questionnaires is 10-15 years (M=4.07, M=3.92). With the availability of more time and a larger sample, perhaps a comparison could be conducted, determining the frequency of disruptive behavior and years of experience as a nurse.

Implications for Future Projects/Research

Longitudinal studies, as well as larger sample sizes, would benefit future research regarding disruptive communication. If the researcher utilizes multiple hospitals to gather data, using the same format for data collection would be more consistent. It would be interesting to use the data found from this scholarly project to teach nurse practitioners

and Doctors the outcomes of disruptive communication, emphasizing the importance of effective communication. Further, it would be insightful to gain nurse practitioners' and Doctors' perspectives regarding poor outcomes and if they experience disruptive behaviors from other NPs, Doctors, or nurses.

Implications for Practice/Health Policy/Education

This study's results indicate the need to emphasize communication styles and techniques in nursing and medical School curriculum. Communication techniques need to be improved, and a common language must be agreed upon by all healthcare fields. A total of 87% of participants agreed that continuing education concerning communication techniques among healthcare professionals needs to be implemented. Boards and private companies may support the dissemination of continuing education.

Policies concerning disruptive communication and bullying have been deliberated among congress in the past. For instance, in 1983, the United States Supreme Court took on the case, *Connick v. Myers* in which they ruled, "First Amendment protections are available for workplace speech only if it covers matters of public concern and does not interfere with the office operations that benefit the public" (Smith & Coel, 2018, p.97). Smith & Coel (2018) elaborate:

> Under Connick v. Myers, anti-bullying regulations could be First Amendment violations only if (1) the alleged bullying speech is about a public concern and (2) the speech is not disruptive to office responsibilities that require productive collaboration to serve the public. (p.99)

This is concerning, for this protects the bullies while leaving the targeted victims and whistleblowers vulnerable. To address this issue, Drs. David C. Yamada, Gary Namie

and Ruth Namie sought state support and law reform by "…persuasively arguing that current employment law has created an invisible workforce that is subject to extreme emotional abuse without legal redress" (Chu, 2014, p.353). Chu (2014) examines that 37% of American workers have been bullied at work (p.27). In 1970, The Occupational Safety and Health Act (OSHA) was signed into law to assure healthy working conditions and safety. However, OSHA does not cover workplace bullying. In 2007, Dr. Yamada and his team submitted The Healthy Workplace Bill to the state of Connecticut Senate to protect the victims of bullying, require the employer to provide compensation for the victim and remove the bully from the work environment (Chu, 2014, p.366). Fortunately, the bill was approved, which provided a step in the right direction toward a comprehensive statute protecting employees. Research like this scholarly project can validate the toxicity of bullying and disruptive behaviors, pushing for further policy change at the federal and state government levels.

Conclusion

The purpose of this study was to identify what types of disruptive behavior nurses are experiencing, discuss outcomes of disruptive behavior, and educate healthcare providers and administrators of disruptive communication. In this study, nurses shared their insight, experiences, and beliefs through quantitative and qualitative analysis. The majority (87%) of participants agreed that continuing education concerning communication techniques among healthcare professionals needs to be implemented. A total of 96.1% of participants agreed that communication between caregivers affects job satisfaction. Job satisfaction is an essential variable for nurse retention rates. Therefore, this study suggests that if institutions want to improve their retention rates during a

nursing crisis, they need to consider policy changes and address disruptive communication.

This study contributes to nursing knowledge, supporting the need for positive communication techniques, revealing adverse outcomes from disruptive communication, and discussing continuing education. This study supports the author's belief that new communication techniques need to be implemented in nursing and physician education. Each member of the interdisciplinary team needs to be aware of communication styles and practices to improve patient care quality and safety.

References

Bylund, C. L., Peterson, E. B., & Cameron, K. A. (2012). A practitioner's guide to interpersonal communication theory: An overview and exploration of selected theories. *Patient Education and Counseling, 87*(3), 261-267. 10.1016/j.pec.2011.10.006

Burroughs, J., & Bartholomew, K. (2014). New ways for doctors and nurses to work together. *Physician Executive, 40*(3), 60-64 https://search.ebscohost.com/login.aspx?direct=true&db=bsh&AN=96107060&site=ehost-live&scope=site

Center, D. (2018). Knowing oneself: The first step to be an effective member of an interprofessional team. *The Journal of Continuing Education in Nursing, 49*(9), 397-399. http://dx.doi.org.library.pittstate.edu/10.3928/00220124-20180813-04

Chu, S. (2014). The workplace bullying dilemma in Connecticut: Connecticut's response to the Healthy Workplace Bill. *Connecticut Public Interest Law Journal, 13*(2), 351-386. https://cpilj.files.wordpress.com/2014/07/13-conn-pub-int-l-j-351.pdf.

Cropanzano, R., & Mitchell, M. S. (2005). Social exchange theory: an interdisciplinary review. *Journal of Management, 31*(6), 875-900. 10.1177/014920630527960

Dixon-Woods M, Campbell A, Martin G, et al. (2019). Improving employee voice about transgressive or disruptive behavior: A case study. *Academic Medicine, 94*(4), 579-585. 10.1097/ACM.0000000000002447

Gordon, M. B., Melvin, P., Graham, D., Fifer, E., Chiang, V. W., Sectish, T. C., & Landrigan, C. P. (2011). Unit-based care teams and the frequency and quality of

physician-nurse communications. *Archives of Pediatrics & Adolescent Medicine*, *165*(5), 424-428. 10.1001/archpediatrics.2011.54

Hailu, F. B., Kassahun, C. W., & Kerie, M. W. (2016). Perceived nurse—physician communication in patient care and associated factors in public hospitals of Jimma Zone, South West Ethiopia: cross sectional study. *Plos One*, *11*(9). 10.1371/journal.pone.0162264.

Khan, A., Rogers, J. E., Melvin, P., Furtak, S. L., Faboyede, M., Schuster, M. A., & Landrigan, C. P. (2015). Physician and nurse nighttime communication and parents' hospital experience. *Pediatrics*, *136*(5), 1-10. 10.1542/peds.2015-2391d

Kimes, A., Davis, L., Medlock, A., & Bishop, M. (2015). 'I'm not calling him!': Disruptive physician behavior in the acute care setting. *Medsurg Nursing: Official Journal of the Academy of Medical-Surgical Nurses*, *24*(4), 223-227. http://library.pittstate.edu:2048/login?url=https://library.pittstate.edu:4471/docview/1705664103?accountid=13211

Kowalski, K. (2018). Creating interprofessional teams. *The Journal of Continuing Education in Nursing*, *49*(7), 297-298. http://dx.doi.org.library.pittstate.edu/10.3928/00220124-20180613-04

Lancaster, G., Kolakowsky-Hayner, S., Kovacich, J., & Greer-Williams, N. (2015). Interdisciplinary communication and collaboration among Doctors, nurses, and unlicensed assistive personnel. *Journal of Nursing Scholarship*, *47*(3), 275-284. 10.1111/jnu.12130

Leonard, M., Graham, S., & Bonacum, D. (2004). The human factor: the critical importance of effective teamwork and communication in providing safe care.

Quality and Safety in Health Care, 13(Suppl1), I85-I90. 10.1136/qhc.13.suppl_1.i85

Manojlovich, M. (2005). Linking the practice environment to nurses' job satisfaction through nurse-physician communication. *Journal of Nursing Scholarship, 37*(4), 367-373. 10.1111/j.1547-5069.2005.00063.x

Manojlovich, M., & DeCicco, B. (2007). Healthy work environments, nurse-physician communication, and patients' outcomes. *American Journal of Critical Care: An Official Publication, American Association of Critical-Care Nurses, 16*(6), 536-543. https://link.gale.com/apps/doc/A171139133/AONE?u=psu_main&sid=AONE&xid=34a165ab

McCaffrey, R. G., Hayes, R., Stuart, W., Cassell, A., Farrell, C., Miller-Reyes, C., & Donaldson, A. (2010). A program to improve communication and collaboration between nurses and medical residents. *The Journal of Continuing Education in Nursing*, *41*(4), 172-178. 10.3928/00220124-20100326-04

Merriam-Webster. (2018). Communication. In Merriam-Webster.com dictionary. Retrieved February 26, 2018, from https://www.merriam-webster.com/dictionary/communication?src=search-dict-hed

Registered Nurses' Association of Ontario (2012). *Managing and mitigating conflict in health-care teams.* Toronto, Canada: Registered Nurses' Association of Ontario. Retrieved June 20, 2018, from http://rnao.ca/sites/rnao-ca/files/Managing-conflict-healthcare-teams_hwe_bpg.pdf

Registered Nurses' Association of Ontario (2012). *Toolkit: Implementation of best practice guidelines.* Toronto, Canada: Registered Nurses' Association of Ontario. Retrieved June 21, 2018, from https://rnao.ca/sites/rnao-ca/files/RNAO_ToolKit_2012_rev4_FA.pdf

Riskin, A., Erez, A., Foulk, T. A., Riskin-Geuz, K. S., Ziv, A., Sela, R., Pessach-Gelblum, L., & Bamberger, P. A. (2017) (2017). Rudeness and medical team performance. *Pediatrics, 139*(2), e20162305. 10.1542/peds.2016-2305

Ritonja, J., Aronson, K. J., Matthews, R. W., Boivin, D. B., & Kantermann, T. (2019). Working Time Society consensus statements: Individual differences in shift work tolerance and recommendations for research and practice. *Industrial health, 57*(2), 201–212. https://doi.org/10.2486/indhealth.SW-5

Robinson, F. P., Gorman, G., Slimmer, L. W., & Yudkowsky, R. (2010). Perceptions of effective and ineffective nurse-physician communication in hospitals. *Nursing Forum, 45*(3), 206-216. 10.1111/j.1744-6198.2010.00182.x

Rosenstein, A.H., O'Daniel, M. (2005). Disruptive behavior and clinical outcomes: Perceptions of nurses and doctors. *American Journal of Nursing*. 2005. *105*(1), 54-64. 10.1097/00000446-200501000-00025

Smith, F. L., & Coel, C. R. (2018). Workplace bullying policies, higher education and the First Amendment: Building bridges not walls. *First Amendment Studies, 52*, 96-111. Retrieved from https://doi.org/10.1080/21689725.2018.1495094.

Thomson, K., Outram, S., Gilligan, C., & Levett-Jones, T. (2015). Interprofessional experiences of recent healthcare graduates: A social psychology perspective on the barriers to effective communication, teamwork, and patient-centered

care. *Journal of Interprofessional Care*, *29*(6), 634–640. https://doi-org.library.pittstate.edu/10.3109/13561820.2015.1040873

Xerri, M. (2012). Workplace relationships and the innovative behaviour of nursing employees: a social exchange perspective. *Asia Pacific Journal of Human Resources*, *51*(1), 103-123. 10.1111/j.1744-7941.2012.00031.x

Zwarenstein, M., Rice, K., Gotlib-Conn, L., Kenaszchuk, C., & Reeves, S. (2013). Disengaged: a qualitative study of communication and collaboration between Doctors and other professions on general internal medicine wards. *BMC Health Services Research*, *13*(1), 1-9. 10.1186/1472-6963-13-494

APPENDIX

APPENDIX A

Disruptive Communication Demographic Survey

The purpose of having this survey is to gather general demographics of the participants in this research study. This helps the researcher have a clearer vision of the participant's outlook and experiences.

1. What is your gender?
    a. Male
    b. Female
    c. Trans Man
    d. Trans Woman
    e. Gender Fluid
    f. I do not wish to respond to this question.
2. How long have you practiced as a Registered Nurse?
    a. 0-1 year
    b. 2-5 years
    c. 5-10 years
    d. 10-15 years
    e. Greater than 15 years
3. What unit do you work on in your current hospital?
    a. Medical-Surgical/General Ward
    b. Intensive Care Unit
    c. Outpatient Clinic
    d. Emergency Department

e. OB/Labor & Delivery

4. How long have you worked on your current unit?
    a. 0-1 year
    b. 2-5 years
    c. 5-10 years
    d. 10-15 years
    e. Greater than 15 years
5. Do you currently work days, evenings, or nights?
    a. Days
    b. Evenings
    c. Nights

APPENDIX B

Pre-Education Questionnaire

The purpose of this study is to determine if a relationship exists between disruptive communication and poor outcomes. The information from this study will help educators and leaders prepare nurses, nurse practitioners, and physicians by educating and training them on the importance of effective communication and patient advocacy. Confidentiality will be ensured by maintaining anonymity. The results from the survey will be viewed by the surveyor. Results from the questionnaire will be used in an educational opportunity. Names and identifying factors will not be shared within the educational opportunity.

1. Communication between caregivers has an effect on job satisfaction.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
2. Communication between caregivers directly affects patient care.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree

Please choose true or false for the following statements.

3. I have felt anxiety before approaching a nurse practitioner or physician for a face-to-face interaction for fear of disruptive communication. (i.e. yelling, sarcasm, belittling, etc.)
    a. True
    b. False
4. I have felt anxiety before calling a nurse practitioner or physician for fear of disruptive communication.
    a. True
    b. False
5. A nurse practitioner or doctor has hung up the telephone on me.
    a. True
    b. False
6. I have hung up the telephone on a nurse practitioner or doctor.
    a. True
    b. False
7. A nurse practitioner or doctor has yelled at me.
    a. True
    b. False
8. I have yelled at a nurse practitioner or doctor.
    a. True
    b. False
9. A nurse practitioner or doctor has belittled me.

a. True

b. False

10. I have belittled a nurse practitioner or doctor.

    a. True

    b. False

11. A nurse practitioner or doctor has cursed at me.

    a. True

    b. False

12. I have cursed at a nurse practitioner or doctor.

    a. True

    b. False

13. A nurse practitioner or doctor has asked me not to call back about a patient situation I found concerning.

    a. True

    b. False

14. A patient was placed in a dangerous situation due to disruptive communication. (i.e. yelling, belittling, hanging up the phone, etc.)

    a. True

    b. False

15. I have witnessed a patient experience harm due to disruptive communication. (i.e. yelling, belittling, hanging up the phone, etc.)

    a. True

    b. False

16. Please explain how the patient was harmed or placed in a dangerous situation resulting from disruptive communication.
17. About how often do you witness disruptive behavior in the workplace?
    a. Daily
    b. Weekly
    c. Monthly
    d. Annually
    e. Almost Never
18. Improvements need to be made regarding communication between nurses, nurse practitioners, and doctors.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
19. Proper communication skills and zero-tolerance policies (such as consequences for disruptive communication) should be enforced in the workplace, nursing schools, and medical schools.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree

20. I feel comfortable contacting a nurse practitioner or physician when needed.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
21. I feel comfortable utilizing the Situation Background Assessment Recommendation (SBAR) format when communicating with a nurse practitioner or physician.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
22. I feel that education regarding positive communication needs to be included in continuing education for nurses, nurse practitioners, and physicians.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
23. I feel that if physicians properly understand the nursing role, they would respect nurses more.

a. Agree

b. Somewhat Agree

c. Neutral

d. Somewhat Disagree

e. Disagree

24. What would you rate your confidence level in addressing disruptive behavior?

a. Confident

b. Somewhat Confident

c. Neutral

d. Somewhat Unsure

e. Unsure

25. If you have any comments or questions about the survey or experience, please leave them here.

Thank you for participating in this study. For any questions or concerns, contact Kristen Linn at (620)-228-3828 or at kristen.linn@gmail.com.

APPENDIX C

Post- Education Questionnaire

The purpose of this study is to determine if a relationship exists between disruptive communication and poor outcomes. The information from this study will help educators and leaders prepare nurses, nurse practitioners, and physicians by educating and training them on the importance of effective communication and patient advocacy. Confidentiality will be ensured by maintaining anonymity. The results from the survey will be viewed by the surveyor. Results from the questionnaire will be used in an educational opportunity. Names and identifying factors will not be shared within the educational opportunity.

1. Improvements need to be made regarding communication between nurses, nurse practitioners, and doctors.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
2. Proper communication skills and zero-tolerance policies (such as consequences for disruptive communication) should be enforced in the workplace, nursing schools, and medical schools.
    a. Agree
    b. Somewhat Agree

c. Neutral

d. Somewhat Disagree

e. Disagree

3. I feel comfortable contacting a nurse practitioner or physician when needed.

    a. Agree

    b. Somewhat Agree

    c. Neutral

    d. Somewhat Disagree

    e. Disagree

4. I feel comfortable utilizing the Situation Background Assessment Recommendation (SBAR) format when communicating with a nurse practitioner or physician.

    a. Agree

    b. Somewhat Agree

    c. Neutral

    d. Somewhat Disagree

    e. Disagree

5. I feel that education regarding positive communication needs to be included in continuing education for nurses, nurse practitioners, and physicians.

    a. Agree

    b. Somewhat Agree

    c. Neutral

    d. Somewhat Disagree

e. Disagree

6. I feel that if physicians properly understand the nursing role, they will respect nurses more.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
7. I am aware of the consequences of my actions and the risks I am taking by ignoring disruptive behavior.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
8. Physicians, nurse practitioners, and administrators should be included in education regarding communication techniques and avoiding disruptive behavior.
    a. Agree
    b. Somewhat Agree
    c. Neutral
    d. Somewhat Disagree
    e. Disagree
    f.

9. What would you rate your confidence level in addressing disruptive behavior?
    a. Confident
    b. Somewhat Confident
    c. Neutral
    d. Somewhat Unsure
    e. Unsure
10. How likely are you to report events that involve disruptive behavior to your supervisor?
    a. Likely
    b. Somewhat Likely
    c. Neutral
    d. Somewhat Unlikely
    e. Unlikely

APPENDIX D

Informed Consent

Title of Research Disruptive Communication Among the Interdisciplinary Team: Gaining Insight and Providing Nurse Education

Principle Investigator, Affiliation and Contact Information
Kristen Anderson, BSN, RN
Pittsburg State University
Irene Ransom Bradley School of Nursing
Email: kristen.linn@gmail.com
Phone: 620-228-3828

Additional Investigators and Affiliations
Kristi Frisbee, DNP, RN
Pittsburg State University
Irene Ransom Bradley School of Nursing
Amanda Alonzo, Ph.D.
Pittsburg State University
Irene Ransom Bradley School of Nursing
Alisha Mason-Collins, Ph.D.
Pittsburg State University

Institutional Contact
Pittsburg State University
Irene Ransom Bradley School of Nursing
Phone: 620-235-4431

Introduction and Purpose of the Study

Communication is a vital skill that every healthcare professional should possess. When healthcare professionals communicate effectively, care is delivered safely and efficiently. However, when communication is disruptive, healthcare professionals have reported dissatisfaction, misinterpretation, medication errors, and mortalities as a result of disruptive communication. The purpose of this study is to validate the relationship between disruptive communication and poor outcomes while teaching nurses communication techniques and how to manage disruptive behavior.

Description of the Research

Participants will be asked to fill out a questionnaire, regarding their personal experience with disruptive communication. Afterwards, they watch a PowerPoint presentation discussing the harmfulness of disruptive communication and how it can be improved. Afterwards, the participant will fill out a second questionnaire regarding the education.

Potential Risks and Discomforts

Risk for participation in this study include, but are not limited to emotional stress/discomfort, loss of confidentiality, and embarrassment.

Potential Benefits

Potential benefits to the subjects include letting participants voices be heard and being part of a research project. Findings from this research project may benefit subjects by

changing policies within their own hospitals once a problem is established. Benefits to the field would be supportive research findings toward disruptive communication and poor outcomes. It would add educational suggestions and findings to the field, as well.

Confidentiality

To maintain the highest level of confidentiality, the collected information will not contain any participant identifier and will be anonymously collected by the researcher. Any identifying material will be omitted from the statistics provided during the educational project. Information will be recorded and stored without any identifiers to maintain obscurity.

Compensation

No compensation will be offered to the subjects.

Voluntary Participation and Authorization

Your decision to participate in this study is complete voluntary. If you decide to not participate in this study, it will not affect the care, services, or benefits to which you are entitled

Withdrawal from the Study and/or Withdrawal of Authorization

If you decide to participate in this study, you may withdraw from your participation at any time without penalty.

Cost/Reimbursements

There is no cost for participating in this study. Any medical expenses resulting from participation in this study will not be reimbursed by the investigators.

I voluntarily agree to participate in this research program

□ Yes

□ No

Note: A copy of the consent will be kept by the Principal Investigator. The participant may print a copy of the consent form if he/she/they wish.

APPENDIX E

Nurse Education

Communication Errors are the **LEADING CAUSE** of Inadvertent Patient Harm

Poor Communication and Patient Outcomes

- "Physician was told twice that sponge count was off. She said, 'they will find it later'. Patient had to be reopened"
- "Cardiologist upset by phone calls and refused to come in. RN told it was not her job to think, just to follow orders. Rx delayed. MI extended"
- "RN called MD multiple times re: deteriorating patient condition. MD upset with RN calling. Patient eventually had to be intubated"
- "RNs did not want to call MD after I.V. ran out. No antibiotic therapy for four days. RN afraid to call MD. Patient expired"

In this study, of survey respondents, 17% knew of an adverse event that occurred as a result of disruptive behavior; 78% of them thought the event could have been prevented.

Qualities Related to Poor Communication Methods

- **Communication Differences**
  - Nurses are taught to look at the "big picture"
  - Physicians are trained to focus on medical issues
- **Hierarchies**
  - Physicians are often considered a "precious resource"
  - "Untouchables"

ORCHESTRA THEORY

Methods to Improve
Communication

- ✓Nonverbal Communication
- ✓Verbal Communication
- ✓SBAR
- ✓Listening Skills

Elements of Nonverbal Communication

Space	Environment	Appearance	Eye Contact
Posture	Gestures	Facial Expressions	Vocal Expression

Verbal Communication Skills

Assertive Communication
Allows people to express themselves in a direct, honest, and appropriate manner.

Passive Communication
When a person suffers in silence although he or she may feel strongly about the issue.

Aggressive Communication
Direct, threatening, and condescending.

Passive-Aggressive Communication
An aggressive message presented in a passive way.

LEARNING EXERCISE

Learning Exercise

1. A coworker withdraws instead of saying what is on his mind.

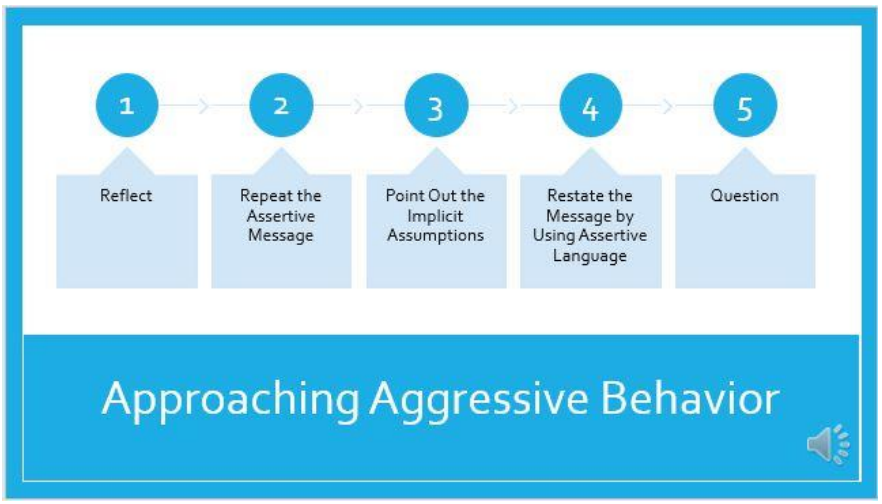
You say, "I guess you are uncomfortable talking about what's bothering you. It would be better if you talked to me".

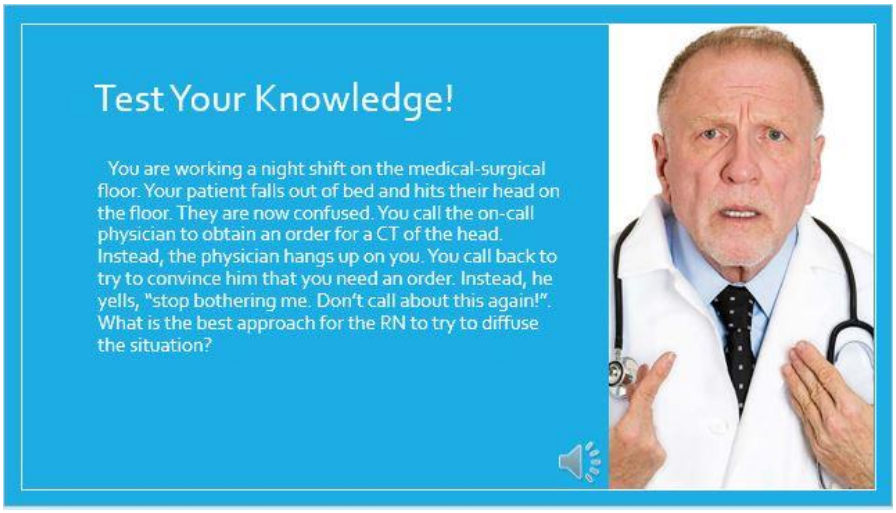
2. In a conversation, a doctor suddenly asks, "What do you women libbers want anyway?"

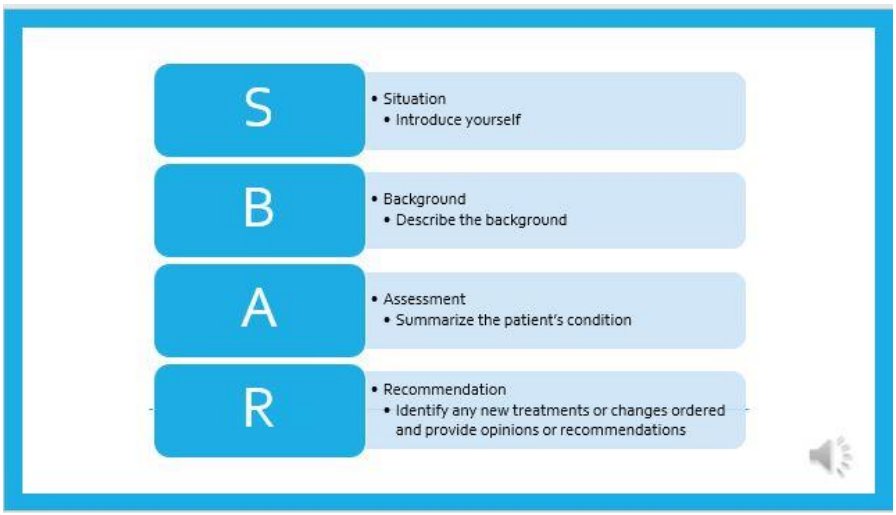
You respond, "Fairness and equality".

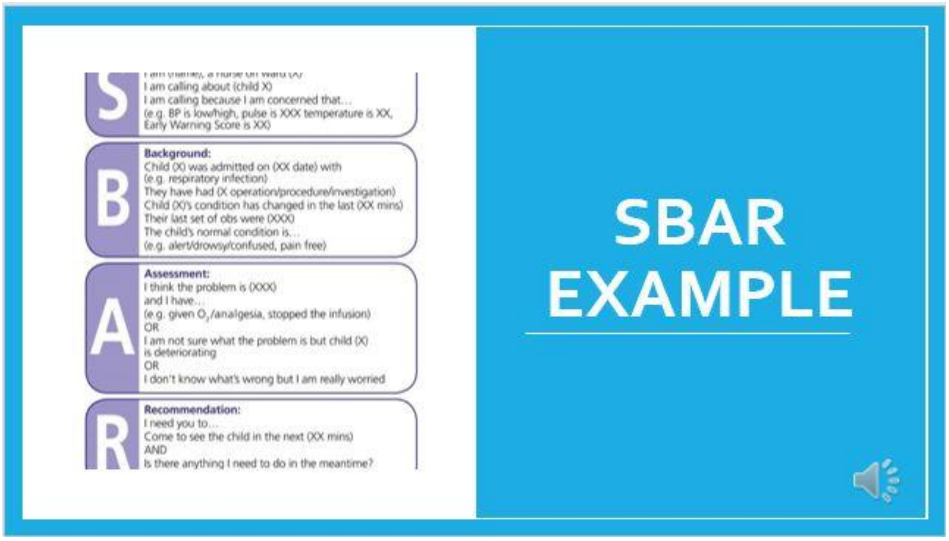
3. A physician asks to borrow your stethoscope.

You say, "Well, I guess so. One of you doctors walked off with mine last week, and this new one cost me $65. Be sure your return it, ok?"


1
2
3
4
5
Reflect
Repeat the Assertive Message
Point Out the Implicit Assumptions
Restate the Message by Using Assertive Language
Question
Approaching Aggressive Behavior


Test Your Knowledge!
You are working a night shift on the medical-surgical floor. Your patient falls out of bed and hits their head on the floor. They are now confused. You call the on-call physician to obtain an order for a CT of the head. Instead, the physician hangs up on you. You call back to try to convince him that you need an order. Instead, he yells, "stop bothering me. Don't call about this again!". What is the best approach for the RN to try to diffuse the situation?


S
• Situation
• Introduce yourself
B
• Background
• Describe the background
A
• Assessment
• Summarize the patient's condition
R
• Recommendation
• Identify any new treatments or changes ordered and provide opinions or recommendations



Case Study

You are assigned to care for a 68-year-old lady for the evening shift. She is two days post-op following hip fracture surgery. No problems were noted at nursing sign-out other than c/o pain, for which she was receiving pain medication. When you perform your initial assessment on this patient, you find her to be confused.

What additional information do you need to gather prior to contacting the physician?

Case Study Continued

The patient's O2 sat is now 88% on up to 50% concentration with the face mask, and her respiratory rate is 30/minute.
You feel she needs almost 1:1 nursing, and are worried about how you will care for your other three patients. You ask if the resident if the patient should be moved to the ICU, but he states he wants to first see how she responds to the antibiotic.

Role Play:

- State your concern
- State information that supports your concerns
- Suggest a course of action
- Recap why you feel this action is best option

Listening Skills

- Greeting
- Respectful Listening
- Review
- Recommend or Request More Information
- Reward

IN CONCLUSION...